Electronically Delivered

October 26, 2022

Administrator
Water's Edge
800 Agency Trail
Mankato, MN 56001

RE: Project Number(s) SL30108015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 29, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500

The total amount you are assessed is $500. 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

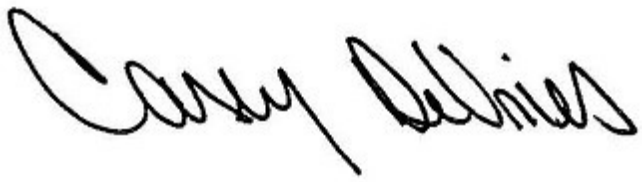
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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
	30108	A. BUILDING: _____ B. WING _____	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATER'S EDGE	800 AGENCY TRAIL MANKATO, MN 56001

(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: SL30108015-0 On September 26, 2022, through September 29, 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 31 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2 and 3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1	0 250		

provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility:
(1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules;
(2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services;
(3) performs any act detrimental to the health, safety, and welfare of a resident;
(4) obtains the license by fraud or misrepresentation;
(5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;
(6) denies representatives of the department access to any part of the facility's books, records, files, or employees;
(7) interferes with or impedes a representative of the department in contacting the facility's residents;
(8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4;
(9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;
(10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;
(11) refuses to initiate a background study under section 144.057 or 245A.04;
(12) fails to timely pay any fines assessed by the

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0 250	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 26, 2022, at approximately 12:20 p.m., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility	0 250		

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0 250	Continued From page 3	0 250		

were familiar with the assisted living regulations and the licensee provided medication and treatment management services.

The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page five and six of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]:

- I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17.

- I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable.

- Assisted Living Licensure statutes in Minn. Stat. chpt. 144G.

- Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.

- Reporting of Maltreatment of Vulnerable Adults.

- Electronic Monitoring in Certain Facilities.

- I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets

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0 250	Continued From page 4	0 250		

requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.

- I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.

- I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.

- I have examined this application and all attachments and checked the above boxes indicating my review and understanding of

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0 250	Continued From page 5 Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by the licensee's authorized agent on May 28, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of September 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (3) handling complaints regarding staff or services provided by staff; (4) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (5) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or	0 250		

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0 250	Continued From page 6 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; (6) orientation to and implementation of the assisted living bill of rights; (7) infection control practices; (8) 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; (9) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (10) medication and treatment management; (11) delegation of tasks by registered nurses or licensed health professionals; (12) supervision of registered nurses and licensed health professionals; and (13) supervision of unlicensed personnel performing delegated tasks. On September 28, 2022, at approximately 3:01 p.m., LALD-A confirmed the licensee reported maltreatment of vulnerable adults, provided orientation, training, and competency evaluations of staff, evaluated staff performance, handled complaints regarding staff or services provided by the staff, conducted initial and ongoing resident evaluations and assessments of resident needs, orientation to and implementation of the assisted	0 250		

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0 250	Continued From page 7 living bill of rights, conducted appropriate screenings or documentation to show that staff were free of tuberculosis, ensured nurses and licensed health professionals had current and valid licenses to practice, medication and treatment management, delegation of tasks by the registered nurse (RN), supervision of the RN and licensed health professionals, and supervision of unlicensed personnel performing delegated tasks; however, failed to develop and implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0250, 0470, 0480, 0500, 0510, 0550, 0640, 0650, 0660, 0680, 0730, 0810, 0910, 0970, 0990, 1040, 1060, 1370, 1380, 1440, 1470, 1620, 1640, 1650, 1770, 1790, 1880, 1890, 1910, 1920, 1930, 1960, and 2170, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans	0 470		

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0 470	Continued From page 8 on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed to determine staffing levels to meet the needs of all residents. This had the potential to affect all 31 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 the residents). The findings include:	0 470		

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0 470	Continued From page 9 The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 36 residents. During the facility tour with licensed assisted living director (LALD)-A and wellness director/licensed practical nurse (WD/LPN)-B on September 26, 2022, at approximately 1:04 p.m., the surveyor observed in the dining room area, a white board containing information on each of the three floors of the facility, that included the date, the scheduled activities for the day, and identified the staff working at the current time on that floor. Throughout the survey, the surveyor observed this information was updated each shift, each day. On September 27, 2022, at 2:22 p.m., assisted living director in training (ALDIT)-D from another facility owned by the same licensee, indicated no staffing plan had been developed to determine the appropriateness of staffing levels. The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule policy dated August 2021, indicated the clinical nurse supervisor, or designee, would develop, write, and implement a staffing plan that would provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven days a week and would address each resident's needs as identified in the service plan and assisted living contract, each resident's acuity level as determined by the most recent assessment or individualized review,	0 470		

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0 470	Continued From page 10 ability to meet the resident's scheduled and reasonably unforeseeable unscheduled needs, and would indicate if the assisted living had a secured dementia care unit. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a	0 480		

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0 480	Continued From page 11 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 September 28, 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 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	0 500		

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0 500	Continued From page 12 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 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	0 500		

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0 500	Continued From page 13 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 entrance conference on September 26, 2022, at approximately 12:20 p.m., licensed assisted living director (LALD)-A stated she reviewed the current assisted living regulations online. The licensee failed to ensure the following policies and procedures were in place and kept current: -orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; -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; -ensuring that nurses and licensed health professionals have current and valid licenses to practice; -delegation of tasks by registered nurses or licensed health professionals; -supervision of registered nurses and licensed health professionals; and -supervision of unlicensed personnel performing delegated tasks. On September 28, 2022, at approximately 3:04 p.m., regional director of clinical services (RDCS)-G indicated the licensee did not have the policies listed above.	0 500		

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0 500	Continued From page 14 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 two of two employees (unlicensed personnel (ULP)-E, ULP-F) observed to provide personal cares and medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	0 510		

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0 510	Continued From page 15 the residents). The findings include: ULP-E On September 27, 2022, at approximately 10:05 a.m., the surveyor observed ULP-E providing personal cares for R6. ULP-E donned gloves, placed a gait belt around R6's waist, assisted R6 to stand from her recliner, and assisted R6 to ambulate into the bathroom while using a walker. ULP-E lowered R6's pants and brief, and assisted R6 to sit on the toilet. ULP-E touched the brief with her gloved hands and announced it was "dry". R6 voided and told ULP-E that she was finished. ULP-E assisted R6 to stand, and ULP-E used a disposable wipe to clean R6's bottom. ULP-E pulled up R6's brief and pants, and without removing the soiled gloves. ULP-E guided R6, touching her walker and the gait belt, to the sink to wash her hands. While R6 washed her hands, ULP-E removed her soiled gloves and tossed them into the trash. Without performing hand hygiene, ULP-E assisted R6 out of the bathroom, touching the walker, R6's arm, the gait belt, the bathroom door and door handle, the door leading into the common area and the door handle and lead R6 to the dining room. ULP-E assisted R6 to sit at the dining room table in a chair, and removed the gait belt. ULP-E pushed R6's chair up to the table and walked away, touching her face near her eye. On September 27, 2022, at approximately 10:14 a.m., ULP-E verified she didn't perform hand hygiene after providing personal cares and removing soiled gloves, and prior to touching multiple surfaces. ULP-F	0 510		

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0 510	Continued From page 16 On September 27, 2022, at approximately 11:15 a.m., the surveyor observed ULP-F preparing to check R7's blood glucose prior to lunch. ULP-F donned gloves, entered R7's room with the blood glucose testing device, cleansed R7'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-F announced to R7 that his blood sugar result was 259. Without removing the gloves, ULP-F left R7's room, touching the door, and walked to the medication cart. ULP-F placed the lancet in the sharps container, removed the gloves, and used hand sanitizer from the top of the medication cart. ULP-F opened the medication cart, took out R7's insulin pen from the top drawer and used the electronic medication administration record to determine the amount of insulin to administer to R7. ULP-F primed the insulin pen by dialing to two units and expelling the insulin, then dialed to six units as ordered. ULP-F donned gloves, walked to R7's room, administered the insulin via the pen, removed the gloves, and without performing hand hygiene, carried the gloves in one hand to the medication cart to dispose of the used needle in the sharps container, and the gloves in the trash. Still without performing hand hygiene, ULP-F put her hand into her pocket to retrieve a key, and unlocked the medication cart. ULP-F placed R7's insulin pen into the medication cart, closed the drawer, and performed hand hygiene with hand sanitizer. On September 27, 2022, at approximately 11:29 a.m., the surveyor observed ULP-F while preparing to administer eye drops for R8. ULP-F entered R8's room, donned gloves, and place one drop in R8's right eye. Without removing the gloves, ULP-F left R8's room and walked to the medication cart. ULP-F removed one glove,	0 510		

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0 510	Continued From page 17 reached into her pocket, unlocked the medication cart and returned the eye drops in the drawer. ULP-F removed the other glove, and performed hand hygiene with the hand sanitizer on top of the medication cart. On September 27, 2022, at approximately 11:39 a.m., ULP-F verified gloves should be removed after performing tasks and hand hygiene should be performed when gloves were removed. During an interview on September 28, 2022, at approximately 4:11 p.m., registered nurse (RN)-C verified gloves should be removed and hand hygiene performed after completing tasks and prior to touching surfaces. The licensee's Infection Control policy, effective February 15, 2020, directed hands should be washed after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have	0 550		

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0 550	Continued From page 18 information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. 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 September 26, 2022, at approximately 1:04 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and wellness director/licensed practical nurse (WD/LPN)-B. The licensee had a bulletin board on the first floor which contained their grievance procedure, but the grievance procedure lacked the information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC), as required. On September 26, 2022, at approximately 1:10 p.m., LALD-A confirmed the posting lacked the above required content. The licensee's Complaint-Grievance policy, effective February 15, 2020, indicated the licensee would ensure the Resident Relations Poster and Human Resource Poster was placed	0 550		

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0 550	Continued From page 19 in the community where it was visible to residents, visitors, and staff, and would include the contact information for the Ombudsman, Adult Protective Services, and the State Regulatory Agency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all of the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a	0 640		

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0 640	Continued From page 20	0 640		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

The licensee failed to:
- post the 911 emergency number in common areas and near telephones provided by the assisted living facility; and
- post information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557.

On September 26, 2022, during the facility tour at approximately 1:04 p.m., the surveyor observed the entry area, common areas, kitchen, and dining room within the facility and noted there was no posting of the 911 emergency number or information and the reporting number for MAARC, as required.

On September 27, 2022, at approximately 12:21 p.m., licensed assisted living director (LALD)-A confirmed the 911 emergency number and the MAARC information was not posted and available to residents, family members, and visitors to the facility.

The licensee's Abuse-Neglect-Exploitation policy, effective February 15, 2020, indicated a copy of the policy would be posted in a common area accessible to residents, visitors, and employees with contact information of the Ombudsman,

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0 640	Continued From page 21 Adult Protective Services, State Regulatory Agency, and the Resident Relations and Human Resources Hotline; however, the policy did not include information and the reporting number for MAARC, and did not direct to post 911 emergency number in common areas and near telephones provided by the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=D	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.	0 650		

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0 650	Continued From page 22 (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a current employee record for each paid employee for one of four employees (registered nurse (RN)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 28, 2022, at approximately 9:50 a.m., licensed assisted living director (LALD)-A stated registered nurse (RN)-C was employed by another facility owned by the same licensee, but that each of the facilities had their own assisted living with dementia care license. LALD-A stated RN-C had been helping at this facility since August 15, 2022, due to a change in staffing. RN-C had a start date of August 15, 2022, at this facility, and provided RN services and on-call services as needed.	0 650		

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0 650	Continued From page 23 RN-C's record lacked the following required content: - evidence of current professional licensure; - records of orientation, infection control training, and competency evaluations; - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings. The surveyor obtained a copy of RN-C's license from the Minnesota Board of Nursing website, which indicated RN-C was first issued a RN license on May 14, 2021, with an expiration date of August 31, 2023. On September 28, 2022, at approximately 9:50 a.m., LALD-A confirmed there was no employee record for RN-C in this facility with the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity	0 660		

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0 660	Continued From page 24 and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included implementation of a TB infection control plan and documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of four employees (registered nurse (RN)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment, dated October 17, 2021, indicated the facility was low risk.	0 660		

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0 660	Continued From page 25 TB INFECTION CONTROL PLAN The licensee lacked a written TB infection control plan to include: - identification and documentation of a qualified person or team with primary responsibility for the TB infection control program, and - procedures for handling persons with suspected or active TB disease. HEALTH HISTORY AND SYMPTOM SCREENING RN-C RN-C started employment on August 15, 2022. RN-C's employee record lacked evidence of completed health history and symptom screening, lacked evidence of baseline screening for presence of TB infection, and lacked evidence of TB training at time of hire, as required. On September 28, 2022, at 3:55 p.m., LALD-A verified the TB infection control program lacked the above content and verified RN-C lacked an employee record with evidence of a completed health history and symptom screening, baseline screening for the presence of TB infection, and evidence of TB training. The licensee's TB Screening policy dated June 5, 2014, noted all staff must document that they do not have TB before providing direct cares to the residents. The policy lacked implementation of a TB infection control program to include the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 660		

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0 660	Continued From page 26 (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to have a written emergency preparedness (EP) plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the	0 680		

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0 680	Continued From page 27 potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the initial tour with licensed assisted living director (LALD)-A and wellness director/licensed practical nurse (WD/LPN)-B on September 26, 2022, at approximately 1:04 p.m., the surveyor observed the facility's layout included one large building with three levels. The first level included a main entrance, large open common area, kitchen, dining room, staff offices, and resident apartments. The second and third levels of the facility mirrored the first level. Although emergency exit diagrams were posted throughout the facility and in residents' apartments on the inside of their apartment door, there was no evidence of signage posted or information regarding the licensee's emergency plan. On September 28, 2022, at approximately 12:10 p.m., LALD-A stated she knew the EP plan was missing some contents, and stated the current emergency preparedness binder was in the LALD's office because she was working on it. LALD-A verified the EP plan was not posted prominently, as required. The plan included a hazard & vulnerability summary, which identified fire and weather-related events as probable events, and included response guidance for each	0 680		

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0 680	Continued From page 28 of these identified events. In addition, the plan included a communication plan and had an arrangement with other facilities owned by the licensee; however, the EP Plan lacked the following content: - process for EP collaboration with regional, State and Federal EP to maintain integrated response; and - communication plan that included contact information for Federal, State, and regional staff, State Licensing and Certification Agency, Minnesota Office of Ombudsman for Long Term Care, and other sources of assistance. The licensee's Disaster Plan policy, undated, indicated the executive director was responsible for the disaster plan, would review and update annually, and would maintain an emergency handbook detailing the procedures for staff to follow in the event of a disaster, that would be kept in a location that was accessible to staff. In addition, the policy indicated the executive director would maintain a current list of persons in line of authority outside the community on an emergency call roster. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of	0 730		

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the resident's emergency contact, legal representatives, and designated representative;
(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;
(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;
(5) the resident's advance directives, if any;
(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;
(7) the facility's current and previous assessments and service plans;
(8) all records of communications pertinent to the resident's services;
(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;
(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;
(11) documentation that services have been provided as identified in the service plan;
(12) documentation that the resident has received and reviewed the assisted living bill of rights;
(13) documentation of complaints received and any resolution;
(14) a discharge summary, including service termination notice and related documentation, when applicable; and
(15) other documentation required under this chapter and relevant to the resident's services or

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0 730	Continued From page 30 status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records included a discharge summary with the required content for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included cirrhosis (scarring) of the liver and acute renal failure (kidney unable to filter wastes from the blood). R4 began receiving services on June 22, 2022, and was discharged on July 12, 2022. R4's Service Plan, dated June 22, 2022, indicated R4 received services including bathing, grooming, dressing, toileting, transfers and ambulation, safety checks, behavior monitoring, housekeeping, laundry, and medication administration. R4's last progress note, dated July 3, 2022, lacked information that R4 was being discharged. R4's record lacked evidence a discharge summary was completed.	0 730		

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0 730	Continued From page 31 On September 27, 2022, at 12:35 p.m., registered nurse (RN)-C stated R4 was "moved" to another facility owned by the licensee, which had a separate assisted living with dementia care license. RN-C verified R4's record lacked a discharge summary. The licensee's Resident Notes policy, dated February 15, 2020, indicated staff would assure a discharge note was added to the charting system indicating the status of the resident at discharge/transfer and the date; however, the policy lacked direction regarding the required contents of the discharge summary. The licensee's Assisted Living-Discharge and Transfer policy, dated February 15, 2020, indicated, "Staff shall assure a discharge note is added to the charting system;" however, the policy lacked direction regarding the required contents of the discharge summary. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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0 810	Continued From page 32 residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to provide required employee and resident training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 810		

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0 810	Continued From page 33 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on September 27, 2022, at approximately 12:50 p.m. with Assisted Living Director in Training (ALDIT)-D and the Licensed Assisted Living Director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. During interview, ALDIT-D and LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, ALDIT-D and LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. During interview, ALDIT-D stated that training was provided annually per policy to employees after orientation. Record review of the available documentation	0 810		

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0 810	Continued From page 34 indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, ALDIT-D stated that the facility did not have documentation or a policy on offering resident training of the fire safety and evacuation plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	0 910		

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0 910	Continued From page 35	0 910		

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

The findings include:

The licensee lacked a written contract with the following required content:
- the contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:
    -the managing agent of the facility, if applicable; and
    -the authorized agent for the facility.

R1's Resident Agreement, dated August 1, 2021, included the managing agent's name and physical mailing address; however, lacked the managing agent's telephone number, as required. In addition, the resident agreement included the name, address, and telephone number for the authorized agent; however, that individual was no longer employed by the licensee.

R2's Resident Agreement, dated June 29, 2022, included the managing agent's name and physical mailing address; however, lacked the managing agent's telephone number, as required. In addition, the resident agreement included the name, address, and telephone number for the authorized agent; however, that individual was no longer employed by the licensee.

R3's Resident Agreement, dated July 1, 2022, included the managing agent's name and physical mailing address; however, lacked the managing agent's telephone number, as required. In addition, the resident agreement included the

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0 910	Continued From page 36 name, address, and telephone number for the authorized agent; however, that individual was no longer employed by the licensee. On September 28, 2022, at approximately 3:40 p.m., regional director of clinical services (RDCS)-G and licensed assisted living director (LALD)-A verified the contract lacked the managing agent phone number and lacked current contact information regarding the authorized agent of the facility. LALD-A verified the same contract was received by all residents living in the facility. The licensee's Assisted Living-Admission Process policy, dated August 30, 2021, indicated the resident or authorized responsible party would sign and receive a copy of the Resident Agreement and Addendums; however, the policy did not address the required contents of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970		

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0 970	Continued From page 37 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Resident Handbook, which was incorporated in and considered part of the assisted living contract, did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Upon entrance on September 26, 2022, at approximately 12:20 p.m., the surveyor requested a copy of the facility's assisted living contract. The licensee's Resident Agreement (contract) included a paragraph on page 10, section 17, "Resident Policies, Rules and Regulations. By signing this Agreement, you agree to abide by and comply with all of the Community's policies, rules and regulations, which have been provided to you in the Resident Handbook. The Resident Handbook is incorporated in and considered part of this Agreement. The Community reserves the right to adopt, amend and discontinue policies, rules and regulations. The Community will provide you with written notice of all such changes." The licensee's Resident Handbook, updated	0 970		

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0 970	Continued From page 38 2020, included a clause on page 8, "Liability. The community is not responsible for loss or damage to your personal property unless we are negligent. You are solely responsible for all decisions made that affect your health, personal property, live [sic], premises, automobile and any other insurance coverage available. We encourage you to purchase rental insurance coverage. We recommend you AVOID keeping large sums of money or valuables in your apartment." On September 28, 2022, at approximately at 3:04 p.m., licensed assisted living director (LALD)-A confirmed the Resident Handbook was given upon admission along with the contract, and was considered part of the assisted living contract. In addition, LALD-A confirmed the contract and handbook provided in the admission packet was the same information provided to all residents. The licensee's Assisted Living-Admission Process policy, dated August 30, 2021, indicated, upon admission the resident or authorized responsible party would sign and receive a copy of the Resident Agreement and addendums, and would receive a copy of the Resident Handbook. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
0 990 SS=D	144G.52 Subd. 2 Prerequisite to termination of a contract (a) Before issuing a notice of termination of an assisted living contract, a facility must schedule and participate in a meeting with the resident and	0 990		

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0 990	Continued From page 39 the resident's legal representative and designated representative. The purposes of the meeting are to: (1) explain in detail the reasons for the proposed termination; and (2) identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid the termination or enable the resident to remain in the facility, including but not limited to securing services from another provider of the resident's choosing that may allow the resident to avoid the termination. A facility is not required to offer accommodations, modifications, interventions, or alternatives that fundamentally alter the nature of the operation of the facility. (b) The meeting must be scheduled to take place at least seven days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting. (c) The facility must notify the resident that the resident may invite family members, relevant health professionals, a representative of the Office of Ombudsman for Long-Term Care, or other persons of the resident's choosing to participate in the meeting. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must notify the resident's case manager of the meeting. (d) In the event of an emergency relocation under subdivision 9, where the facility intends to issue a notice of termination and an in-person meeting is impractical or impossible, the facility may attempt to schedule and participate in a meeting under this subdivision via telephone, video, or other means.	0 990		

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0 990	Continued From page 40 This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to schedule and participate in a meeting with the resident and the resident's legal representative and designated representative prior to termination of a contract for one of one resident (R4) who had services terminated. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's record lacked evidence the facility conducted the required meeting with the resident and the resident's legal representative and designated representative prior to terminating her contract. R4's diagnoses included cirrhosis (scarring) of the liver and acute renal failure (kidney unable to filter wastes from the blood). R4 began receiving services on June 22, 2022, and was "moved" from the facility on July 12, 2022, to another assisted living with dementia care facility owned by the same licensee and held a separate license. R4's Service Plan dated June 22, 2022, indicated R4 received services including bathing, grooming, dressing, toileting, transfers and ambulation,	0 990		

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0 990	Continued From page 41 safety checks, behavior monitoring, housekeeping, laundry, and medication administration. R4's last progress note, dated July 3, 2022, lacked information that R4 was being discharged. On September 27, 2022, at approximately 12:35 p.m., registered nurse (RN)-C stated the facility "wasn't a good fit," for R4; however, R4's transfer was not emergent and verified the facility failed to conduct the required meeting prior to the proposed termination of services. The licensee's Assisted Living-Discharge and Transfer policy, dated February 15, 2020, indicated state specific requirements for discharge and transfer varied from state to state; however, the licensee would assure compliance with State Law and Regulations and established procedures for the discharge or transfer process. The policy indicated a 30-day discharge notice may be issued; however, lacked direction regarding a meeting prior to termination of a contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 990		
01040 SS=D	144G.52 Subd. 7 Notice of contract termination required (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who	01040		

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01040	Continued From page 42 receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to issue a written notice for a termination of contract at least 30 days ahead of the termination, or at least 15 days ahead of an expedited termination, and failed to provide documentation supporting the need for an expedited termination of the contract for one former resident (R4). In addition, the licensee failed to send a copy of the termination notice to the Office of Ombudsman for Long Term Care (LTC). This practice resulted in a level two violation (a	01040		

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01040	Continued From page 43	01040		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

On September 27, 2022, at approximately 12:35 p.m., registered nurse (RN)-C stated R4 began receiving services on June 22, 2022, and was "moved" from the facility on July 12, 2022, to another assisted living with dementia care facility owned by the same licensee, with a separate license, because "this wasn't a good fit for her."

R4's diagnoses included cirrhosis (scarring) of the liver and acute renal failure (kidney unable to filter wastes from the blood).

R4's Service Plan dated June 22, 2022, indicated R4 received services including bathing, grooming, dressing, toileting, transfers and ambulation, safety checks, behavior monitoring, housekeeping, laundry, and medication administration.

R4's last progress note, dated July 3, 2022, lacked information that R4 was being discharged.

R4's record lacked a discharge summary.

R4's record lacked documentation supporting the need for an expedited termination of R4's contract. R4's record lacked evidence R4 received a written termination notice. In addition, R4's record lacked evidence a copy of a

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01040	Continued From page 44 termination notice was sent to the Office of Ombudsman for LTC, as required. On September 27, 2022, at approximately 12:41 p.m., RN-C stated R4's transfer was not emergent and R4 was not a threat or a risk to anyone or to herself, and verified the facility failed to issue a written notice of termination, as required. In addition, RN-C could not verify a copy of a termination notice was sent to the Office of Ombudsman for LTC, as required. The licensee's Assisted Living-Discharge and Transfer policy, dated February 15, 2020, indicated state specific requirements for discharge and transfer varied from state to state; however, the licensee would assure compliance with State Law and Regulations and established procedures for the discharge or transfer process. The policy indicated a 30-day discharge notice may be issued for the following: - the resident is in violation of the Residency Agreement; - the resident fails to comply with the Community Policies or rules as listed in the Resident Handbook; - the resident fails after reasonable notice to pay or have a third party pay for the residency; - the resident refuses to allow the Community to complete a required assessment; - the resident refuses to sign the service plan; - the resident exhibits behavior of threat to self or others; or - the resident has experienced a significant change and needs a higher level of care, which cannot be provided by the Community. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01040		

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01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (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	01060		

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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 two of two residents (R2, R3) and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (R2).

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

The findings include:

R2
R2's diagnoses included hyperglycemia (high blood sugar), iron deficiency anemia, congestive heart failure, and dementia.

R2's progress notes noted:
- July 27, 2022, R2 was found lying on the floor at 9:40 a.m., with no apparent injury. At 11:59 a.m., R2 was being assisted to the bathroom while in wheelchair. R2 became unresponsive, and slid out of wheelchair, with staff assisting to floor. R2 began vomiting and was placed on his side. 911 was called. R2 was admitted to the hospital with blood in his stool, low hemoglobin and possible gastrointestinal bleed.

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01060	Continued From page 47 - July 29, 2022, wellness director/licensed practical nurse (WD/LPN)-B spoke with nursing staff at hospital. R2 would be discharged on August 1, 2022. - August 1, 2022, registered nurse (RN)-C noted R2 had returned from the hospital with new medication orders. R2's Service Plan, dated June 29, 2022, indicated R2 received services including assistance with showering, grooming, dressing, toileting, transfers and ambulation, safety checks, behavior monitoring, laundry, housekeeping, and medication administration. R2's record lacked evidence of a written notice provided to the resident, the resident's 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 has been relocated and any new service provider; - contact information for the OOLTC; - 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 - 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. In addition, R2's record lacked notification to the OOLTC that R2 had been relocated and had not returned to the facility within four days. R3	01060		

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R3's diagnoses included Crohn's Disease (chronic inflammation of the digestive tract), dementia, chronic obstructive pulmonary disease, anxiety, and atrial fibrillation (irregular and faster heartbeat).

R3's progress notes noted:
- August 13, 2022, at 6:20 a.m., R3 was going to shower, and the shower head fell and hit his leg, causing a varicose vein to rupture. Staff applied pressure and called 911. R3 was taken to the emergency department and family was notified. Dermabond (medical skin adhesive) was applied and R3 returned to the facility. At 11:45 a.m., R3 reported he was taking off his hospital socks and the varicose vein "ruptured again". Staff applied pressure and R3 was taken to the emergency department. Family was notified. R3 was admitted to the hospital and placed on telemetry (process of recording) to monitor due to having a syncope (fainting) episode in the emergency department.
- August 14, 2022, update received from nursing staff at hospital. R3 had no further bleeding from varicose vein, telemetry results were normal, and hemoglobin was low. Plan to update tomorrow.
- August 15, 2022, R3 has had no further bleeding, hemoglobin improving. Will have surgery consult post-hospitalization. R3 was discharged from the hospital and returned to the facility.

R3's Service Plan, dated June 30, 2022, indicated R3 received services including assistance with bathing, grooming, dressing, toileting, transfers and ambulation, safety checks, behavior monitoring, laundry, housekeeping, and medication administration.

R3's record lacked evidence of a written notice

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provided to the resident, the resident's 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 has been relocated and any new service provider;
- contact information for the OOLTC;
- 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
- 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.

On September 29, 2022, at approximately 9:10 a.m., RN-C and WD/LPN-B stated they were not aware of the need to provide the notice, and verified no written notice was provided to R2 or R3.

The licensee's Emergency Care policy, undated, noted when an assisted living resident experienced a medical emergency, staff should call 911, stay with the resident until help arrived, give copies of necessary information to emergency personnel, notify responsible person, notify the physician, notify the director of wellness, complete an incident report, send a copy of the incident report to the licensing agency, and document the incident in the 24-hour log. The policy lacked direction to provide a written notice with the required content for an emergency relocation and failed to include direction to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency

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01060	Continued From page 50 relocation if greater than four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for	01370		

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the resident and the resident's preferences, cultural background, and family;
(12) awareness of confidentiality and privacy;
(13) understanding appropriate boundaries between staff and residents and the resident's family;
(14) procedures to use in handling various emergency situations; and
(15) awareness of commonly used health technology equipment and assistive devices.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel (ULP-F, ULP-E) to include all required content.

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-F was hired on October 11, 2021, to provide direct care services to residents of the facility.

On September 27, 2022, at approximately 11:15 a.m., the surveyor observed while ULP-F prepared to check R7's blood sugar. ULP-F donned gloves, obtained R7's glucose monitoring device from the medication cart, placed a test

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strip in the device, and walked to R7's room. ULP-F proceeded to poke R7's finger with the lancet, obtained a drop of blood, and placed the drop onto the test strip. ULP-F announced the result was 259 and exited R7's room to gather supplies to administer his insulin.

ULP-F's employee record lacked documentation of training and competency evaluations for the following:
- documentation requirements for all services provided;
- communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and
- understanding appropriate boundaries between staff and residents and the resident's family.

ULP-E
ULP-E was hired on August 23, 2022, to provide direct care services to residents of the facility.

On September 27, 2022, at approximately 10:05 a.m., the surveyor observed ULP-E while assisting R6 with toileting and assisting with ambulation to the common area to have her nails painted.

ULP-E's employee record lacked documentation of training for the following topics:
- documentation requirements for all services provided;
- communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and
- understanding appropriate boundaries between staff and residents and the resident's family.

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01370	Continued From page 53 On September 28, 2022, at approximately 3:15 p.m., registered nurse (RN)-C stated the licensee's previous RN had provided training to the ULP in the facility, and RN-C could not confirm if ULP-F and ULP-E had the above training and competency testing. The licensee lacked policies that addressed training and competency testing requirements for unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	01380		

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01380	Continued From page 54 Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP-F) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F ULP-F was hired on October 11, 2021, to provide direct care services to residents of the facility. On September 27, 2022, at approximately 11:15 a.m., the surveyor observed while ULP-F prepared to check R7's blood sugar. ULP-F donned gloves, obtained R7's glucose monitoring device from the medication cart, placed a test strip in the device, and walked to R7's room. ULP-F proceeded to poke R7's finger with the lancet, obtained a drop of blood, and placed the drop onto the test strip. ULP-F announced the result was 259 and exited R7's room to gather supplies to administer his insulin. ULP-F's employee record contained documents which listed training and demonstration topics; however, lacked information related to the following required training: - basic knowledge of body functioning and changes in body functioning, injuries, or other	01380		

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01380	Continued From page 55 observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. On September 28, 2022, at approximately 3:15 p.m., registered nurse (RN)-C stated the licensee's previous RN had provided training to ULP-F, and could not confirm if ULP-F had the above required training and competency testing. The licensee lacked policies that addressed training and competency testing requirements for unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing	01440		

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01440	Continued From page 56 delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted supervision of unlicensed staff as required for one of two employees (unlicensed personnel (ULP)-F) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired on October 11, 2021, to provide direct care services to residents of the facility. On September 27, 2022, at approximately 11:15 a.m., the surveyor observed while ULP-F prepared to check R7's blood sugar. ULP-F donned gloves, obtained R7's glucose monitoring device from the medication cart, placed a test strip in the device, and walked to R7's room. ULP-F proceeded to poke R7's finger with the lancet, obtained a drop of blood, and placed the drop onto the test strip. ULP-F announced the	01440		

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01440	Continued From page 57 result was 259 and exited R7's room to gather supplies to administer his insulin. ULP-F's record lacked evidence an RN conducted direct supervision of ULP-F within 30 days of performing delegated tasks. On September 28, 2022, at approximately 3:15 p.m., registered nurse (RN)-C stated she was not employed by this facility during that time and could not confirm if ULP-F had been supervised by a registered nurse within 30 days of performing delegated tasks. The licensee lacked a policy regarding supervision of unlicensed personnel performing delegated tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
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);	01470		

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01470	Continued From page 58 (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 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	01470		

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01470	Continued From page 59 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 assisted living licensing requirements and regulations prior to providing services for four of four employees reviewed (registered nurse (RN)-C, wellness director/licensed practical nurse (WD/LPN)-B, unlicensed personnel (ULP)-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-C, WD/LPN-B, ULP-E, and ULP-F's records lacked evidence to indicate the employees received orientation to include the required topics. RN-C RN-C started employment on August 15, 2022, to provide assisted living services to the licensee's residents, and to provide supervision of the licensee's employees. RN-C lacked an employee record and lacked the following required orientation content: - an overview of Assisted Living statutes; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470		

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01470	Continued From page 60 person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. WD/LPN-B WD/LPN-B started employment on March 8, 2022, to provide assisted living services to the licensee's residents. WD/LPN-B's record lacked the following required content: - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. ULP-E ULP-E was hired on August 23, 2022, to provide direct care services to residents of the facility.	01470		

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01470	Continued From page 61 ULP-E's record lacked the following required content: - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. ULP-F ULP-F was hired on October 11, 2021, to provide direct care services to residents of the facility. ULP-F's record lacked the following required content: - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. On September 28, 2022, at approximately 3:09 p.m., licensed assisted living director (LALD)-A stated RN-C was also employed at another facility owned by the licensee; however, confirmed each facility had their own assisted living with dementia care license. LALD-A indicated she was not aware RN-C needed to have an employee record at this facility, with documentation of completion of the orientation requirements. Also, LALD-A verified WD/LPN-B, ULP-E, and ULP-F's records included documentation of completion of the Minnesota Home Care Bill of Rights for Clients of Licensed Only Home Care Providers, dated November 2019, instead of the current Minnesota Bill of Rights for Assisted Living Residents. The licensee lacked policies that addressed orientation to assisted living licensing requirements and regulations prior to providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		

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01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment after a change of condition for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01620		

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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 September 26, 2022, at approximately 12:20 p.m., registered nurse (RN)-C stated comprehensive assessments were completed upon admission, within 14 days, every 90 days and with changes in condition.

R5's diagnoses included dementia, psychotic disturbance, mood disturbance, anxiety disorder, high blood pressure, and enlarged prostate.

R5's Service Plan, dated October 20, 2021, indicated R5 received services which included medication management, assistance with dressing, grooming, toileting, transfers, safety checks every two hours, daily activities, daily behavior monitoring, and weekly laundry and housekeeping.

R5's Meridian Eval _MN-V2, identified as the "quarterly" assessment, dated May 11, 2022, indicated R5 had a history of falling and had a score that identified a fall risk, and noted R5 had fallen in the past three months. In addition, the assessment indicated a task of wellness checks due to falls with a goal to minimize injuries; however, did not identify additional interventions to reduce the resident's risk for injury.

R5's Meridian Eval_MN-V2, identified as the "quarterly" assessment, dated August 3, 2022, indicated R5 had a history of falling and had a

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01620	Continued From page 64	01620		

score that identified a fall risk, and noted R5 had fallen in the past three months. In addition, the assessment indicated a task of wellness checks due to falls with a goal to minimize injuries; however, did not identify additional interventions to reduce the resident's risk for injury.

R5's Fall Risk Assessment/Evaluation, dated August 3, 2022, indicated R5 had "1-2 falls" in the last three months, used an assistive device, had mild gait impairment, was independent with transfers, had contributing factors, was alert with adequate vision, and had "1-2" medications prescribed. R5's fall risk score was noted as "13." The evaluation indicated a score of 10 or greater was considered at risk for falls.

R5's record included the following Accident/Injury Reports and Fall Investigation Checklists:
- May 7, 2022, at 6:05 p.m., R5 had an unwitnessed fall in his bathroom. R5 reported he needed to use the bathroom, slipped off the toilet onto the floor and landed on his buttocks. Call light was within reach. No injuries noted. The medical provider was notified at 6:50 p.m. The report was reviewed and signed by a RN on May 9, 2022.
- May 30, 2022, at 10:30 p.m., R5 had an unwitnessed fall while getting out of bed. R5 reported he "lost footing" while getting out of bed. No injuries noted. The medical provider was notified on May 31, 2022. There was no indication the RN was notified, and the report was reviewed and signed by a licensed practical nurse (LPN) on May 31, 2022, not by a RN.
- June 11, 2022, at 4:15 p.m., R5 had an unwitnessed fall while transferring from his bed to his wheelchair. R5 reported he "lost footing." R5 sustained a skin tear on his right elbow. The medical provider was notified on June 13, 2022.

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01620	Continued From page 65 There was no indication the RN was notified, and the report was reviewed and signed by a LPN on June 13, 2022, not by a RN. - July 14, 2022, at 2:00 a.m., R5 had an unwitnessed fall when he "slid down wall, while trying to get to chair." R5 sustained a skin tear on his left elbow. The medical provider was notified on July 18, 2022. There was no indication the RN was notified, and the report was reviewed and signed by a LPN on July 18, 2022, not by a RN. - July 17, 2022, at 8:15 p.m., R5 had unwitnessed fall when he "self-transferred onto bed, got to edge, & slid off onto floor." R5 reported he slid off of his bed. No injuries noted. The medical provider was notified on July 17, 2022, at 8:35 p.m. by email. There was no indication the RN was notified, and the report was reviewed and signed by a LPN on July 18, 2022, not by a RN. - July 18, 2022, at 9:00 p.m., R5 had an unwitnessed fall when he self-transferred and lost his footing. R5 reported he "lost footing." No injuries noted. The medical provider was notified on July 19, 2022. There was no indication the RN was notified, and the report was reviewed and signed by a LPN on July 19, 2022, not by a RN. - July 28, 2022, at 10:30 p.m., R5 had an unwitnessed fall when he self-transferred from his bed to wheelchair and slipped onto the floor. R5 reported he "slipped." No injuries noted. The medical provider was notified on July 29, 2022. There was no indication the RN was notified, and the report was reviewed and signed by a LPN on July 29, 2022, not by a RN. - September 12, 2022, at 11:30 p.m., R5 had an unwitnessed fall while transferring to the toilet. R5 reported he "lost balance." No injuries noted. The medical provider was notified on September 13, 2022. There was no indication the RN was notified, and the report was reviewed and signed by a LPN on September 13, 2022, not by a RN.	01620		

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01620	Continued From page 66 Review of R5's progress notes included documentation of each of the above falls; however, all documentation was completed by unlicensed personnel (ULP) and/or LPN, not by the RN. R5's record lacked evidence the RN completed an assessment to assess for causative factors to determine individualized interventions to reduce the resident's risk for injury. On September 28, 2022, at approximately 4:03 p.m., wellness director (WD)/LPN-B and RN-C stated residents were reminded often to pull the cord in their room when needing assistance; however, interventions weren't always documented. RN-C stated she was aware of R5's reoccurring falls; however, verified a reassessment was not completed to assess for causative factors, and no interventions were determined to reduce R5's falls and the risk for injury. The licensee's Falls policy, dated February 15, 2020, indicated, "The Community will assess Residents regarding fall risk prior to and at admission, after each fall, at each required assessment and following a significant change." The policy directed, when a resident has a fall, the Wellness Director [whom is an LPN] will assure the resident is reassessed, appropriate supervision and interventions are in place, and follow-up is completed. Also included, "For repetitive falls, the Community will reassess the Resident. The Community will work with the Medical Provider and physical therapist to provide any additional interventions to reduce the risk of falls."	01620		

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01620	Continued From page 67 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (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 observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for one	01640		

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01640	Continued From page 68	01640		

of three residents (R1) reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1's Service Plan, dated August 26, 2022, lacked a signature or other authentication by the resident, documenting agreement on the services to be provided.

On September 27, 2022, at approximately 11:49 a.m., the surveyor observed R1 in his room, visiting with his "mental health worker."

On September 27, 2022, at approximately 10:32 a.m., registered nurse (RN)-C stated R1's service plan was revised on August 23, 2022, and she had signed it; however, confirmed it lacked a signature by the resident as required. RN-C stated R1's last service plan was dated September 1, 2021, and she was in the process of updating all residents' service plans to ensure accuracy since she started at this facility, but hadn't completed all of them yet.

The licensee's Assessment Service Plan policy, dated February 15, 2020, indicated the service plan would be completed to include the requirements of State law and regulations within the required time frames, and when accepted, would be signed by the resident, authorized responsible party, Wellness Director and other

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01640	Continued From page 69 involved staff if appropriate or required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650		

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This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for three of three residents reviewed (R1, R2, R3).

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

The findings include:

R1, R2, and R3's service plans lacked the following required content:
- the schedule of monitoring assessments of the resident;
- the method of monitoring staff providing services; and
- a contingency plan that includes:
  - information and a method to contact the facility.

R1
R1's diagnoses included type 2 diabetes, anxiety, and sleep apnea.

On September 27, 2022, at approximately 11:49 a.m., the surveyor observed R1 in room, visiting with his "mental health worker."

R1's Service Plan, dated August 23, 2022, indicated R1 required medication management, bathing, grooming, dressing, toileting, safety

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01650	Continued From page 71	01650		

checks, housekeeping and laundry, and daily activities. The Service Plan indicated the template was a product of the Aging Services of Minnesota Comprehensive Home Care Policies & Procedures Manual, dated January 2014, instead of the current Assisted Living licensure requirements, therefore, lacked the required content noted above.

R2
R2's diagnoses included dementia, type 2 diabetes, and history of falling.

On September 28, 2022, at approximately 12:46 p.m., the surveyor observed R2 eating independently in the dining room, visiting with a resident across the table. At 1:03 p.m., R2 asked for his walker and used the walker to independently ambulate to his room.

R2's Service Plan, dated June 29, 2022, indicated R2 received services including assistance with showering, grooming, dressing, toileting, transfers and ambulation, safety checks, behavior monitoring, laundry, housekeeping, medication administration, and daily activities.
The Service Plan indicated the template was a product of the Aging Services of Minnesota Comprehensive Home Care Policies & Procedures Manual, dated January 2014, instead of the current Assisted Living licensure requirements, therefore, lacked the required content noted above.

R3
R3's diagnoses included Crohn's Disease (chronic inflammation of the digestive tract), dementia, chronic obstructive pulmonary disease, anxiety, and atrial fibrillation (irregular and faster heartbeat).

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01650	Continued From page 72 On September 27, 2022, at approximately 11:55 a.m., the surveyor observed R3 ambulating independently in his room, pacing back and forth, with loud music playing on a device. R3 stated he was having a "bad day" and music helped calm him. R3's Service Plan, dated June 30, 2022, indicated R3 received services including assistance with bathing, grooming, dressing, toileting, transfers and ambulation, safety checks, behavior monitoring, laundry, housekeeping, medication administration, and daily activities. The Service Plan indicated the template was a product of the Aging Services of Minnesota Comprehensive Home Care Policies & Procedures Manual, dated January 2014, instead of the current Assisted Living licensure requirements, therefore, lacked the required content noted above. On September 28, 2022, at approximately 4:00 p.m., registered nurse (RN)-C verified the service plan lacked the required content and stated the same service plan was utilized for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
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.	01770		

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01770	Continued From page 73 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup was completed accurately at the time of set up for one of one resident reviewed (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 September 26, 2022, at approximately 12:20 p.m., registered nurse (RN)-C and wellness director/licensed practical nurse (WD/LPN)-B stated the licensee provided medication management services for all of the licensee's residents, including weekly medication set up for three residents, for later administration by unlicensed personnel (ULP). The surveyor requested RN-C notify the surveyor when she or WD/LPN-B were preparing to complete medication set up during the survey, so the surveyor could observe the process. R8's diagnoses included dementia, type 2 diabetes, personality disorder, hyperlipidemia (high concentration of fat in the blood), hypothyroidism (low activity of the thyroid gland), thrombocytopenia (deficiency of platelets in the blood causing bleeding), bipolar disorder, anxiety, repeated fall, weakness, chronic kidney disease,	01770		

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01770	Continued From page 74 and preglaucoma. R8's MAR (Medication Administration Record), printed October 4, 2022, included: - amlodipine (treat high blood pressure) 2.5 mg (milligrams) one tablet by mouth (po) every morning; - atorvastatin (used to lower cholesterol) 40 mg one tablet po at bedtime; - divalproex (treat manic and mixed episodes related to bipolar disorder) extended release 500 mg two tablets po at bedtime; - glipizide (lowers blood sugar) 5 mg, one-half tablet po twice daily with meals; - ketorolac tromethamine (treat eye pain or itching) 0.5% solution one drop in each eye four times daily for 6 weeks; - levothyroxine (treat underactive thyroid) 137 mcg (micrograms) one tablet po every morning; - melatonin (sleep aide) 3 mg two tablets po at bedtime; - metformin (lowers blood sugar) 1000 grams one tablet po twice daily with meals; - moxifloxacin hydrochloride (treat bacterial infection) 0.5% solution instill one drop in left eye four times a day; - prednisolone acetate (treat inflammation) 1% suspension instill one drop in right eye twice daily and left eye four times daily; - rivastigmine (treat dementia) 6 mg one capsule po twice daily; - trazadone (treat depression) 100 mg one tablet po at bedtime; - Viibryd (treats major depressive disorder) 40 mg one tablet po every morning; and - vitamin D2 (supplement) 50,000 units one capsule po every other week. R8's record lacked documentation of weekly medication set up.	01770		

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01770	Continued From page 75 On September 28, 2022, at approximately 1:18 p.m., the surveyor again requested to observe the medication set up, as requested upon entrance. WD/LPN-B stated all residents' medications had been set up for the week, so there would be no opportunity to observe the process. WD/LPN-B described the process displaying R8's medications and stated she followed the MAR on the electronic medical record, confirming each medication, time ordered, and verified each medication again as she set the medications up in pill bars. When asked how she documented the medications she set up, WD/LPN-B stated there was no process in place to document the medications set up, and stated she wasn't sure if the electronic medical record had the capability to document each medication that was set up. The licensee's Medication Program policy, dated February 15, 2020, indicated all medications managed by the Community must be packaged according to the Community's specifications. Residents who do not use the Community's pharmacy must ensure medications are packaged or repackaged according to the Community's specifications, unless it is not feasible to do so (i.e. medications provided by the Veterans Administration). The policy lacked direction for medication set up and documentation of the medication set up. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will	01790		

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01790	Continued From page 76 (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the	01790		

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01790	Continued From page 77 medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01790		

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01790	Continued From page 78 The findings include: During the entrance conference on September 26, 2022, at approximately 12:20 p.m., licensed assisted living director (LALD)-A and RN-C stated the licensee provided medication management services to the licensee's residents. The licensee's Medication Program policy, dated February 15, 2020, included a paragraph titled, "Out of Building-Leave of Absence" Medications, which indicated, for extended leave of absence (more than three days), the pharmacy would prepare the medications. For short leave of absences (less than three days), the policy directed to place the resident's medications into appropriate containers, count and record medications on the Medication Release form, have the resident or responsible party sign/date the form if more than one dose was needed, and provide written instructions for the residents. Upon return, the policy directed staff to determine if all medications were taken and to document results on the Release form and report any variance in the count to the Wellness Director. On September 28, 2022, at approximately 4:08 p.m., RN-C stated she couldn't verify if ULP had been trained to give residents medications for unplanned time away because she had recently started at this facility, and stated she was not aware of written procedures for the unlicensed personnel to follow when completing this task. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

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01880	Continued From page 79	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and/or document medication refrigerator temperatures for two of two medication refrigerators (2nd floor, 3rd floor). 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 September 26, 2022, at approximately 12:20 p.m., registered nurse (RN)-C stated the licensee provided medication management services to the licensee's residents, including storage of medications. RN-C stated the licensee had a medication cart on each of the three floors and two medication refrigerators. On September 28, 2022, at approximately 2:10 p.m., the surveyor observed the medication	01880		

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refrigerators on the 3rd and 2nd floor, with wellness director/licensed practical nurse (WD/LPN)-B and unlicensed personnel (ULP)-F. The 3rd floor refrigerator was a dorm-type refrigerator, located in a cupboard, in a small charting room with a door that had a lock. The refrigerator contained two boxes of unopened insulin pens. The refrigerator temperature was 41 degrees Fahrenheit (F). The surveyor observed water dripping from the small freezer compartment within the refrigerator, onto the boxes, and the boxes were saturated with water. ULP-F stated she didn't know who was responsible for monitoring the refrigerators or if the refrigerator temperatures were monitored. The 2nd floor refrigerator was a dorm-type refrigerator, located in a cupboard, in a small charting room with a door that had a lock. The refrigerator contained nine Humalog Kwikpen (fast acting insulin) pens, nine Lantus Solostar (long-acting insulin) pens, five Aspar Flex Pens (fast acting insulin), and Boostrix (injectable booster immunization for tetanus, diphtheria, pertussis). The 2nd floor refrigerator temperature was 34 degrees F and the surveyor observed ice buildup on the inside walls of the refrigerator.

On September 28, 2022, at approximately 2:20 p.m., WD/LPN-B stated she thought the temperature of the medication refrigerators should be between 30-35 degrees F, and stated, "We look at it. If it's above 40 [degrees F], we know it's not right." WD/LPN-B verified there was no system in place to monitor the medication refrigerators and/or the temperatures of the refrigerators.

The manufacturer's instructions for Humalog Kwikpen, dated September 2022, indicated it was recommended that unopened insulin be stored in

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01880	Continued From page 81 a refrigerator at approximately 36 to 46 degrees F to maintain potency. Do not use insulin that has been frozen. The manufacturer's instructions for Lantus Solostar, dated May 2022, indicated unused pens should be refrigerated between 36-46 degrees F. Do not freeze. The manufacturer's instructions for Aspar Flex Pens, dated June 2021, indicated pens not in use should be refrigerated at 36-46 degrees F. The manufacturer's instructions for Boostrix, dated October 12, 2022, indicated storage in the refrigerator between 36-46 degrees F. Do not freeze. Discard if the vaccine has been frozen. The licensee's Medication Program policy, dated February 15, 2020, indicated the Wellness Director (or designee) would check and record the refrigerator temperature daily using the Temperature Log, and temperatures must be maintained between 36 and 48 degrees F. In addition, variances of greater than 2 degrees above or below the operating standards should be reported to the Executive Director (or designee). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed	01890		

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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 medications were maintained with the open date and the expiration date for time sensitive medications for two of two residents reviewed (R2, R10). In addition, the licensee failed to ensure medications with time sensitive dates were not expired, for one of one resident (R9) reviewed during observation of medication storage.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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:

During the entrance conference on September 26, 2022, at approximately 12:20 p.m., registered nurse (RN)-C stated the licensee provided medication management services to all of the licensee's residents, including storage of medications. RN-C stated the licensee had a medication cart on each of the three floors.

On September 28, 2022, at approximately 1:48 p.m., the surveyor completed a review of the

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licensee's three medication carts in the presence of registered nurse (RN)-C, wellness director/licensed practical nurse (WD/LPN)-B, and unlicensed personnel (ULP)-F, who confirmed the findings.

R2's NovoLog FlexPen (fast acting insulin), dispensed July 1, 2022, was opened; however, lacked a date indicating when it was opened and when it would expire.

R10's latanoprost (treat glaucoma) 0.005% eye drops, dispensed November 22, 2021, were opened; however, lacked a date indicating when it was opened and when it would expire.

R9's latanoprost 0.005% eye drops, dispensed May 23, 2022, had a handwritten date of May 24, 2022, which ULP-F stated was the date on which the bottle was opened. ULP-F indicated R9 received the eye drops daily, in the evening.

On September 28, 2022, at approximately 2:05 p.m., RN-C stated medications with time sensitive expiration dates should be labeled with the opened date, when opened. Also, medications should be monitored to ensure they were not kept past the expiration date.

The manufacturer's instructions for NovoLog FlexPen, dated June 2021, indicated the pen should be discarded 28 days after first use, even if there was insulin still in the pen.

The manufacturer's instructions for latanoprost eye drops, dated February 1, 2022, indicated the eye drops should be kept in the refrigerator and discarded six weeks after opening.

The licensee's Medication Program policy, dated

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01890	Continued From page 84 February 15, 2020, did not address time sensitive medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R4) upon discharge.	01910		

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01910	Continued From page 85 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's record lacked documentation of medication disposition upon R4's discharge from the facility. R4 was discharged on July 12, 2022, after receiving services for diagnoses including cirrhosis (scarring) of the liver and acute renal failure (kidney unable to filter wastes from the blood). R4's Service Plan, dated June 22, 2022, indicated R4 received services including bathing, grooming, dressing, toileting, transfers and ambulation, safety checks, behavior monitoring, housekeeping, laundry, and medication administration. R4's record lacked a discharge summary. On September 27, 2022, at 12:35 p.m., registered nurse (RN)-C stated R4 was "moved" to another facility owned by the licensee, which had a separate assisted living with dementia care license. RN-C verified R4's record lacked documentation of the disposition of R4's medications upon discharge. The licensee's Medication Program policy, dated	01910		

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01910	Continued From page 86 February 15, 2020, indicated unused medications would be recorded on a Medications Returned for Destruction form and returned to the pharmacy or disposed per the community's disposal procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01920 SS=F	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement procedures for loss and spillage of all controlled substances defined in Minnesota Rules	01920		

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01920	Continued From page 87 part 6800.4220. 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 September 26, 2022, at approximately 12:20 p.m., registered nurse (RN)-C confirmed the licensee provided medication management services to residents, including storage of controlled substances. On September 28, 2022, at approximately 1:34 p.m., the surveyor observed the licensee's secure storage of controlled substances with wellness director/licensed practical nurse (WD/LPN)-B. On September 28, 2022, at approximately 3:04 p.m., regional director of clinical services (RDCS)-G and registered nurse (RN)-C indicated the licensee lacked a procedure for loss or spillage of controlled substances, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01920		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services	01930		

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01930	Continued From page 88 must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The 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:	01930		

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01930	Continued From page 89 During the entrance conference on September 26, 2022, at approximately 12:20 p.m., licensed assisted living director (LALD)-A and RN-C confirmed the licensee provided treatment management services. The surveyor requested to review the licensee's policies and procedures upon entrance to the facility. The licensee lacked policies and procedures that addressed: - 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. On September 28, 2022, at approximately 3:04 p.m., regional director of clinical services (RDCS)-G and RN-C indicated the licensee lacked the above required policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930		
01960 SS=F	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must	01960		

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include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not administered, and any follow up procedures that were provided to meet the resident's needs, for one of one resident (R1) who received a new prosthesis.

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

The findings include:

The licensee failed to document skin checks every two to four hours, as ordered.

R1's diagnoses included type 2 diabetes, anxiety, and history of left below the knee amputation.

R1's Service Plan, dated August 23, 2022, indicated R1 required medication management, bathing, grooming, dressing, toileting, safety checks, housekeeping and laundry, and daily activities.

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01960	Continued From page 91 R1's prescriber orders dated September 22, 2022, indicated R1 was provided a new prosthesis for his left lower leg. The order included, "New prosthesis, please take prosthesis off every 2 [two]- [to] 4 [four] hrs [hours] to check skin." The order also included placing gray compression socks at night. On September 27, 2022, at approximately 11:49 a.m., the surveyor observed R1 in his room, visiting with his "mental health worker." R1's record lacked evidence that skin checks had been completed, as ordered by the prescriber, and lacked evidence the compression socks were applied at night. On September 29, 2022, at approximately 9:16 a.m., wellness director/licensed practical nurse (WD/LPN)-B confirmed there was no evidence of documentation of R1's skin checks and compression socks being completed as directed by the prescriber, and stated she could not confirm that this was being completed, as ordered. WD/LPN-B stated there was no process in place for the unlicensed personnel to document the completion of treatments or therapies. The licensee lacked treatment or therapy management policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA	02170		

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02170	Continued From page 92 (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	02170		

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review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation for three of three residents (R1, R2, R3) who resided in the assisted living with dementia care facility.

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

The findings include:

The facility had an assisted living with dementia care license, effective August 1, 2022, through September 30, 2023.

R1
R1's diagnoses included type 2 diabetes, anxiety, and sleep apnea.

R1's Service Plan, dated August 23, 2022, indicated R1 required medication management, bathing, grooming, dressing, toileting, safety checks, housekeeping and laundry, and daily activities.

On September 27, 2022, at approximately 11:49 a.m., the surveyor observed R1 in his room, visiting with his "mental health worker."

R1's Resident Life Story, dated February 16, 2022, included past and current interests, current abilities and skills, emotional and social needs and patterns, physical abilities and limitations,

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and adaptations necessary for R1 to participate in activities. Although the assessment included identification of activities for behavioral interventions, the area was left blank. In addition, R1's record lacked an individualized activity plan based on the activity evaluation that reflected R1's activity preferences and needs, as required.

R2
R2's diagnoses included dementia, type 2 diabetes, and history of falling.

R2's Service Plan, dated June 29, 2022, indicated R2 received services including assistance with showering, grooming, dressing, toileting, transfers and ambulation, safety checks, behavior monitoring, laundry, housekeeping, medication administration, and daily activities.

On September 28, 2022, at approximately 12:46 p.m., the surveyor observed R2 eating independently in the dining room, visiting with a resident across the table. At 1:03 p.m., R2 asked for his walker, and used the walker to independently ambulate to his room.

R2's Memorable Experience Profile, undated, indicated R2 grew up on a farm, did not attend college, and served two years in the military. The remaining questions on the assessment were blank, and a small note was attached, indicating R2 "refused to complete." R2's record lacked an evaluation for activities that addressed the following:
- past and current interests;
- current abilities and skills;
- emotional and social needs and patterns;
- physical abilities and limitations;
- adaptations necessary for the resident to participate; and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30108	A. BUILDING: _____ B. WING _____	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATER'S EDGE	800 AGENCY TRAIL MANKATO, MN 56001

(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
02170	Continued From page 95 - identification of activities for behavioral interventions. In addition, R2's record lacked an individualized activity plan based on the activity evaluation that reflected R2's activity preferences and needs. R3 R3's diagnoses included Crohn's Disease (chronic inflammation of the digestive tract), dementia, chronic obstructive pulmonary disease, anxiety, and atrial fibrillation (irregular and faster heartbeat). R3's Service Plan, dated June 30, 2022, indicated R3 received services including assistance with bathing, grooming, dressing, toileting, transfers and ambulation, safety checks, behavior monitoring, laundry, housekeeping, medication administration, and daily activities. During the initial facility tour on September 26, 2022, at approximately 1:06 p.m., with licensed assisted living director (LALD)-A and wellness director/licensed practical nurse (WD/LPN)-B, a loud bang was heard near the elevator. LALD-A and WD/LPN-B stated R3 was having a "bad day." On September 27, 2022, at approximately 11:55 a.m., the surveyor observed R3 ambulating independently in his room, pacing back and forth, with loud music playing on a device. R3 stated he was having a "bad day" and music helped calm him. On September 28, 2022, at approximately 2:59 p.m., loud noises and yelling could be heard from inside R3's room, through the closed door. Registered nurse (RN)-C stated R3 needed	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30108	A. BUILDING: _____ B. WING _____	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATER'S EDGE	800 AGENCY TRAIL MANKATO, MN 56001

(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
02170	Continued From page 96	02170		

toothpaste and "this is just how he is." RN-C went into R3's room and talked with him until he calmed down.

R3's Memorable Experience Profile, dated June 30, 2022, was completed by R3's power of attorney. The profile included R3's family information, career history, and favorite memories including music, concerts, and cooking. The profile included past life engagement interests, which included puzzles, magazines, games, drawing, checkers, chess, painting, journaling, and painting.

R3's record lacked an evaluation for activities that addressed the following:
- current abilities and skills;
- emotional and social needs and patterns;
- physical abilities and limitations;
- adaptations necessary for the resident to participate; and
- identification of activities for behavioral interventions.

In addition, R3's record lacked an individualized activity plan based on the activity evaluation that reflected R3's activity preferences and needs.

On September 29, 2022, at approximately 9:37 a.m., life enrichment coordinator (LEC)-H verified the current evaluation for activities lacked the above required contents and confirmed an individualized activity plan was not developed for each resident, based on the activity evaluation, that reflected each resident's activity preferences and needs.

The licensee's Assisted Living-Admission Guidelines For Residents with Early Stage Dementia policy, dated February 15, 2020,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30108	A. BUILDING: _____ B. WING _____	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATER'S EDGE	800 AGENCY TRAIL MANKATO, MN 56001

(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
02170	Continued From page 97 indicated an assessment would be done prior to admission by the Wellness Director (or designee) to include an "Assessment of ability to participate in group activities." The policy lacked the required contents of the activity evaluation and the development of an individualized activity plan for each resident based on their activity evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

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

Type: Full
Date: *09/28/22*
Time: 11:05:14
Report: 1020221122

Food and Beverage Establishment Inspection Report

Location:
Water'S Edge
800 Agency Trail
Mankato, MN56001
Blue Earth County, 07

Establishment Info:
ID #: 0039192
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073888582
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.

4-200 Equipment Design and Construction

4-201.11AMN

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

THE DOMESTIC DISHWASHERS USED IN ALL 3 KITCHENS DO NOT
REACH TEMPERATURES HIGH ENOUGH TO MEET THE UTENSIL SURFACE REQUIREMENT OF 160F. ACCORDING TO SPECIFICATION SHEETS THEY ARE NOT DESIGNED FOR LICENSED FOOD ESTABLISHMENTS.

Comply By: 05/31/23

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

MOLD GROWTH ON THE BAFFLE OF THE ICE MACHINE FOUND ON THE 1ST FLOOR KITCHEN; CLEAN.

Comply By: 10/03/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

DOORS TO CABINETS ARE SEPARATING BY 2 BAY SINKS ON ALL 3 FLOORS. REPAIR SO DOORS REMAIN SMOOTH, WIPEABLE, AND EASILY CLEANABLE.

Comply By: 05/31/23

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: CHICKEN CORDON - UPRIGHT COOLER, 1ST FLOOR KITCHEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: CHEESE - UPRIGHT COOLER, 1ST FLOOR KITCHEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - UPRIGHT FREEZER, 1ST FLOOR KITCHEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - UPRIGHT FREEZER, 2ND FLOOR FREEZER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: MILK - UPRIGHT COOLER, 2ND FLOOR KITCHEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: MILK - UPRIGHT COOLER, 3RD FLOOR KITCHEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - UPRIGHT FREEZER, 3RD FLOOR KITCHEN
Violation Issued: No

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

GENERAL COMMENTS:

DISCUSSED EMPLOYEE ILLNESS POLICIES AND PROCEDURES. AN EMPLOYEE ILLNESS LOG AND ILLNESS REPORTING REQUIREMENTS FACT SHEET WAS PROVIDED WITH THE REPORT.

FOOD IS MADE FOR SAME DAY, IMMEDIATE SERVICE. LEFTOVERS, IF ANY, ARE SAVED

Food and Beverage Establishment Inspection Report

FOR NO MORE THAN 3 DAYS. ANY LEFTOVER FOOD ITEMS ARE COOLED IN A SMALL CONTAINER AND PLACED IN THE UPRIGHT COOLER. ANY LEFTOVER FOOD REUSED IS REHEATED FOR IMMEDIATE SERVICE. MOST OF FOOD ITEMS ARE PREPARED ON THE MAIN FLOOR KITCHEN AND TRANSPORTED BY CAMBRO CARTS TO DIFFERENT FLOORS AND SERVED IMMEDIATELY. ALL FOOD TEMPS ARE TAKEN UPON ARRIVAL TO EACH FLOOR PRIOR TO FOOD BEING SERVED.

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 1020221122 of 09/28/22.

Certified Food Protection Manager: Ryan Wieneke

Certification Number: FM52916 Expires: 04/09/25

Inspection report reviewed with person in charge and emailed.

Signed: Report emailed
Establishment Representative

Signed:
Ashley B

651-201-4500

Report #: 1020221122

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	1	Date	09/28/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:05:14
Legal Authority MN Rules Chapter 4626		Time Out	

Water'S Edge	Address: 800 Agency Trail	City/State: Mankato, MN	Zip Code: 56001	Telephone: 5073888582
License/Permit #: 0039192	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Surpervision			
1 IN OUT	PIC knowledgeable; duties & oversight		
2 IN OUT N/A	Certified food protection manager, duties		
Employee Health			
3 IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4 IN OUT	Proper use of reporting, restriction & exclusion		
5 IN OUT	Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6 IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7 IN OUT N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8 IN OUT N/O	Hands clean & properly washed		
9 IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10 IN OUT	Adequate handwashing sinks supplied/accessible		
Approved Source			
11 IN OUT	Food obtained from approved source		
12 IN OUT N/A N/O	Food received at proper temperature		
13 IN OUT	Food in good condition, safe, & unadulterated		
14 IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15 IN OUT N/A N/O	Food separated and protected		
16 IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17 IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18 IN OUT N/A N/O	Proper cooking time & temperature		
19 IN OUT N/A N/O	Proper reheating procedures for hot holding		
20 IN OUT N/A N/O	Proper cooling time & temperature		
21 IN OUT N/A N/O	Proper hot holding temperatures		
22 IN OUT N/A	Proper cold holding temperatures		
23 IN OUT N/A N/O	Proper date marking & disposition		
24 IN OUT N/A N/O	Time as a public health control: procedures & records		
Consumer Advisory			
25 IN OUT N/A	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26 IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27 IN OUT N/A	Food additives: approved & properly used		
28 IN OUT	Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29 IN OUT N/A	Compliance with variance/specialized process/HACCP		

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

GOOD RETAIL PRACTICES

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

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30		IN OUT N/A Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32		IN OUT N/A Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34		IN OUT N/A N/O Plant food properly cooked for hot holding		
35		IN OUT N/A N/O Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) Report emailed **Date:** 10/10/22

Inspector (Signature)