DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 3, 2022

Administrator
Elysian Senior Homes Of Lake City
480 West Grant Street
Lake City, MN 55041

RE: Project Number(s) SL31876015

Dear Administrator:

On April 19, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 2, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 3, 2022

Administrator
Elysian Senior Homes Of Lake C
480 West Grant Street
Lake City, MN 55041

RE: Project Number(s) SL31876015

Dear Administrator:

On February 25, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on December 2, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the December 2, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on December 2, 2021, found not corrected at the time of the February 25, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0650-Employee Records-144g.42 Subd. 8
0730-Contents Of Resident Record-144g.43 Subd. 3
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) - $500.00
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
1770-Documentation Of Medication Setup-144g.71 Subd. 9
2310-Appropriate Care And Services-144g.91 Subd. 4 - $3,000.00

The details of the violations noted at the time of this follow-up evaluation completed on February 25, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up evaluation completed on February 25, 2022, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - $3,000.00
0970-Waivers Of Liability Prohibited-144.50 Subd. 5

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

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.
We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917 .

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31876	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOMES OF LAKE C	480 WEST GRANT STREET LAKE CITY, MN 55041

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL31876015-1 On February 24, 2022, through February 25, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 2, 2021. At the time of the survey, there were 55 residents, 47 of whom received services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued. An immediate correction order was identified on February 25, 2022, issued for SL31876015-1, tag identification 2310. On March 1, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of G.	{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.	

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0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on February 25, 2022, with records 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	0 340		

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0 340	Continued From page 2 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). The findings include: During the revisit survey on February 24, 2022, through February 25, 2022, surveyors reviewed the licensee's policies and procedures, resident records, employee records, and conducted interviews with president (P)-I, corporate registered nurse (CRN)-N and RN-M. The licensee lacked evidence to indicate the orders issued on December 2, 2021, were corrected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{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	{0 480}		

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{0 480}	Continued From page 3 This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 650} SS=C	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation,	{0 650}		

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{0 650}	Continued From page 4 employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for four of four employees (unlicensed personnel (ULP)-D, ULP-C, ULP-S and ULP-T) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D started employment on April 18, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-D's record lacked documented evidence of the following required training: - review of the types of Assisted Living services the employee would provide and the provider's scope of license. ULP-C ULP-C started employment on April 18, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021.	{0 650}		

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{0 650}	Continued From page 5 ULP-C's record lacked documented evidence of the following required training: - review of the types of Assisted Living services the employee would provide and the provider's scope of license. ULP-S ULP-S began providing assisted living services on December 27, 2021. ULP-S's record lacked documented evidence of the following required training: - review of the types of Assisted Living services the employee would provide and the provider's scope of license. ULP-T ULP-T began providing assisted living services on February 15, 2022. ULP-T's record lacked documented evidence of the following required training: - review of the types of Assisted Living services the employee would provide and the provider's scope of license. On February 25, 2022, at 9:10 a.m., president (P)-I stated review of the types of Assisted Living services the employee would provide and the provider's scope of license had been missed for all employees, and it was meant to be sent out for all employees to be read and acknowledged through their electronic system. The licensee's Employee Records policy dated August 1, 2021, noted the employee record would include records of all training provided. No further information was provided.	{0 650}		

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{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 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;	{0 730}		

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{0 730}	Continued From page 7 (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 status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure resident records contained all records of communication pertinent to resident services for one of four residents (R4) with records 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: R4's record lacked documentation of communication with an outside provider to include signed prescriber orders. On February 25, 2022, at approximately 8:43 a.m., the surveyor observed R4 eating breakfast in his bed. R4's record included a hospice plan of care, dated October 1, 2021, which indicated hospice election with skilled nurse, home health aide,	{0 730}		

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{0 730}	Continued From page 8 medical social worker, chaplain, and massage therapist visits. R4's Service Plan Agreement dated January 1, 2022, noted services including medication administration and assistance with activities of daily living. R4's record contained an order dated January 14, 2022, to discontinue sooth and cool moisture barrier topical ointment 98.3%. However, the order was unsigned by the prescriber. On February 25, 2022, at approximately 3:44 p.m., president (P)-I stated they called the hospice provider to send the signed order back today, as the licensee did not have a signed copy. The licensee's Medication and Treatment Orders policy, dated August 1, 2021, noted a written prescriber's order must be obtained for any medication administration provided to a resident, and the registered nurse (RN) was responsible to ensure a current, authorized prescriber order for medications administered by staff was kept on file in the resident's record. In addition, the policy noted the order must be signed by the prescriber. No further information was provided.	{0 730}		
{0 810} SS=E	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	{0 810}		

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{0 810}	Continued From page 9 a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (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: No further action required.	{0 810}		
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	0 970		

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0 970	Continued From page 10 include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure 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: The licensee's assisted living contract included three clauses that indicated the resident would waive the facility's liability for health, safety or personal property of a resident. -Page 10, section 10 (a) of the contract indicated "We have no responsibility to you or any third party for any personal property placed in the apartment or on any other location within the company by you or the owner of such personal property. We are not responsible to you or any third party for harm or loss of any personal property by theft or any other cause. You assume all risk for harm to or loss of any of your personal property and agree to release, indemnify, defend, and hold us harmless from any and all liability with respect to harm to or loss of any of your	0 970		

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0 970	Continued From page 11 personal property." -Page 10, section 10 (b) of the contract indicated "You are solely responsible for personal injury, property damage, or other loss as a result of your owning, maintaining, operating and/or parking of a motor vehicle on or off the premises of the company. You assume all risk for harm to or loss of your motor vehicle, and agree to release, indemnify, defend, and hold us harmless from any and all liability connected with your owning, maintaining, operating, and/or parking a motor vehicle." -Page 10, section 10 (c) indicated "You acknowledge familiarity with the apartment, the company premises and services of the company and are therefore are willing to, and do, assume all risks associated with occupancy. You further acknowledge that we are not an insurer of your safety. The company, its employees, and its agents are not liable to you or to any other person for any loss of inconvenience of any kind, including personal injuries sustained by you or any other person, or any loss or damage to property of any kind, including personal injuries sustained by you or any other person, or any loss or damage to property, which is not the direct result of our intentional or negligent acts in violation of applicable standards of care. We are not responsible for the actions of, or for any damages, injury or harm cause by third parties (such as other residents, family members, guests, intruders, or trespassers) who are not under our control. On February 25, 2022, at 3:47 p.m., president (P)-I verified the licensee's contract included the above content, and stated the same contract was utilized for all residents at the facility. The licensee's Signing an Assisted Living	0 970		

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0 970	Continued From page 12 Contract policy dated August 1, 2022, lacked information on the content of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
{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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{01650}	Continued From page 13 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 four of four residents (R10, R2, R4 and R11) with records 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 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: R10 R10's Service Plan Agreement lacked the following required content: - the schedule of monitoring assessments of the resident; and - a contingency plan that included identification of and information as to who has authority to sign for the resident in an emergency. R10's Service Plan Agreement dated February 10, 2022, noted services including medication administration and assistance with activities of daily living. The agreement had two people listed as an emergency contact but failed to include if they had the authority to sign for the resident in an emergency. In addition, the agreement failed to identify the following schedule and method of monitoring assessments of the resident: - an assessment would be completed for a	{01650}		

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{01650}	Continued From page 14 prospective resident prior to the date on which a prospective resident executed a contract with the facility or the date on which a prospective resident moved in. R2, R4 and R11's Service Plan lacked the following required content: - the schedule of monitoring assessments of the resident. R2 R2's Service Plan Agreement dated December 16, 2021, noted services including medication administration and assistance with activities of daily living. However, the agreement failed to identify the following schedule and method of monitoring assessments of the resident: - an assessment would be completed for a prospective resident prior to the date on which a prospective resident executed a contract with the facility or the date on which a prospective resident moved in. On February 25, 2022, at approximately 12:33 p.m., the surveyor observed R2 asleep on the couch. R4 R4's Service Plan Agreement dated January 1, 2022, noted services including medication administration and assistance with activities of daily living. However, the agreement failed to identify the following schedule and method of monitoring assessments of the resident: - an assessment would be completed for a prospective resident prior to the date on which a prospective resident executed a contract with the facility or the date on which a prospective resident moved in.	{01650}		

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{01650}	Continued From page 15 On February 25, 2022, at approximately 8:43 a.m., the surveyor observed R4 eating breakfast in his bed. R11 R11's Service Plan Agreement dated January 27, 2022, noted services including medication administration and assistance with activities of daily living. However, the agreement failed to identify the following schedule and method of monitoring assessments of the resident: - an assessment would be completed for a prospective resident prior to the date on which a prospective resident executed a contract with the facility or the date on which a prospective resident moved in. On February 25, 2022, president (P)-I verified the licensee removed the above required content from the service plans, and that the same service plans were utilized for all residents. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include a schedule and method for the next planned assessment and monitoring. No further information was provided.	{01650}		
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of	{01760}		

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{01760}	Continued From page 16 administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document the site of injection for one of two residents (R2) with records 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: R2's Service Plan Agreement dated December 16, 2021, noted services including medication administration and assistance with activities of daily living. R2's prescriber orders dated February 7, 2022, included an order for Lantus SoloStar, inject 50 units subcutaneously (SQ) every day. The resident's Medication Sheet for January 24, 2022, through February 23, 2022, included the order for Lantus SoloStar (prefilled insulin pen) give 20 units SQ daily. The medication sheet	{01760}		

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{01760}	Continued From page 17 included a spot for each date and staff initials to indicate the medication had been administered. However, it lacked a space to indicate the site the insulin was administered on the resident's body. On February 25, 2022, at approximately 4:30 p.m., registered nurse (RN)-M confirmed R2's records lacked identification of the site the Lantus insulin was being administered. In addition, RN-M stated this appeared to be an issue with pharmacy entering the order, and not clicking a button to include the site. The package insert from Lantus SoloStar pen dated March 2020, noted to rotate the injection sites within the area chosen for each dose, to reduce the risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. It also noted do not use the same spot or inject where the skin is pitted, thickened, lumpy, tender, scaly, hard, scarred, or damaged. The licensee's policy Medication Management Administration and Setup, dated August 8, 2021, indicated for medication administration the documentation would include the medication name, dosage, date and time administered, and method and route of administration. The licensee's policy Insulin, dated August 1, 2021, indicated insulin medication would be administered according to the prescriber orders. No further information was provided.	{01760}		
{01770} SS=E	144G.71 Subd. 9 Documentation of medication setup	{01770}		

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{01770}	Continued From page 18 Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for three of three residents (R16, R17, and R18) with records 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 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 revisit entrance conference on February 24, 2022, at approximately 11:05 a.m., president (P)-I and corporate registered nurse (CRN)-N confirmed the licensee provided medication management services to the licensee's residents. R16, R17, and R18's records lacked documentation by the licensed nurse at the time of medication setup to include: - the name of the medication, - quantity of dose, - times to be administered, and	{01770}		

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{01770}	Continued From page 19 - route of administration. R16 R16's Service Plan Agreement dated December 17, 2021, noted services including medication setup and administration. R16's prescriber orders dated February 18, 2022, included one antihypertensive, one blood thinner, and one antidepressant. R16's Service Checkoff List for February 2022, noted scheduled services to include: - Medication: Setup. Nurses sign off medication setup in the electronic medication administration record (EMAR). Nurse to set-up medications in weekly med box or fill oral syringes per provider order. R16's Medication List printed date February 25, 2022, noted: - Apixaban 2.5 milligram (mg) tabs - twice daily - every Tuesday - 1 tablet orally - Nurse to setup seven-day supply in a.m. and p.m. labeled mediboxes for unlicensed staff to administer to resident. Take 1 tablet twice daily for blood thinner; - Calcium-Vitamin D 600-400 mg tabs - daily - every Tuesday - 1 tablet orally - Nurse to setup seven-day supply in a.m. labeled mediboxes for unlicensed staff to administer to resident. Take 1 tablet by mouth daily for supplement; - Metoprolol Tartrate 50 mg tabs - twice daily - every Tuesday - 1 tablet orally - Nurse to setup seven-day supply in a.m. and p.m. labeled mediboxes for unlicensed staff to administer. Take 1 tablet by mouth twice daily for hypertension; - Zoloft 25 mg tabs - daily - every Tuesday - 1 tablet orally - Nurse to setup seven-day supply in	{01770}		

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{01770}	Continued From page 20 a.m. labeled box for unlicensed staff to administer for depression; and - Spironolactone-HCTZ 25-25 mg tablets - daily - every Tuesday - 1 tablet orally - Take 1 tablet by mouth daily. Nurse to setup seven-day supply in medibox in am labeled box for unlicensed staff to administer for hypertensive heart disease with heart failure. R17 R17's Service Plan Agreement dated December 17, 2021, noted services including medication setup and administration. R17's prescriber orders dated December 16, 2021, included one pain reliever and one medication for overactive bladder. R17's Service Checkoff List for February 2022, noted scheduled services to include: - Medication: Setup. Nurse to setup medications in weekly medication box or fill oral syringes per provider order. R17's Medication List printed date February 25, 2022, noted: - Aspirin 325 mg tabs - daily - every Tuesday - 1 tablet orally - Nurse to setup seven-day supply in a.m. labeled medibox for unlicensed staff to administer. Take 1 tablet by mouth daily for prevention; - Lipitor 40 mg tablets - daily at bedtime - every Tuesday - take 1 tablet by mouth daily at bedtime for hyperlipidemia (high cholesterol); - Celexa 10 mg tabs - daily - every Tuesday - 1 tablet orally - nurse to setup seven-day supply in a.m. labeled mediboxes for unlicensed staff to administer to resident. Take 1 tablet by mouth daily for depression;	{01770}		

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{01770}	Continued From page 21 - Fish oil 1000 mg caps - daily - every Tuesday - 1 capsule orally - nurse to setup seven-day supply in a.m. labeled mediboxes for unlicensed staff to administer to resident. Take 1 capsule by mouth for supplement; - levetiracetam 500 mg tabs - twice daily - 1 tablet orally - nurse to setup seven-day supply in a.m. and p.m. labeled mediboxes for unlicensed staff to administer to resident. Take 1 tablet by mouth daily for seizure control; - levothyroxine sodium 75 microgram (mcg) tabs - daily - every Tuesday - 1 tablet orally - nurse to setup seven-day supply in a.m. labeled mediboxes for unlicensed staff to administer to resident. Take 1 tablet by mouth daily for hypothyroidism (underactive thyroid); - Ocutabs-Lutein tabs - daily - every Tuesday - 1 tablet orally - nurse to setup seven-day supply in a.m. labeled mediboxes for unlicensed staff to administer to resident. Take 1 tablet by mouth daily for supplement; and - oxybutynin chloride 5 mg tab - twice daily - every Tuesday - 1 tablet orally - take 1 tablet by mouth twice a day - nurse to setup seven-day supply in a.m. and p.m. labeled mediboxes for unlicensed staff to administer to resident for urinary. R18 R18's Service Plan Agreement dated December 28, 2021, noted services including medication setup. R18's prescriber orders dated February 17, 2022, included three medications for hypertension and one for depression. R18's Service Checkoff List for February 2022, noted scheduled services to include: - Medication: Setup. Setup medications in medibox and deliver full box to resident's	{01770}		

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{01770}	Continued From page 22 apartment. R18's Medication List printed date February 25, 2022, noted: - aspirin 325 mg tags - daily by mouth - every Thursday - nurse to setup seven-day supply in a.m. labeled medibox for resident to self-administer. Take 1 tablet by mouth daily for hypertension; - calcium carbonate - Vitamin D 500-200 mg - twice daily - every Thursday - 1 tablet orally - nurse to setup seven-day supply in a.m. and p.m. labeled mediboxes for resident to self-administer. Take 1 tablet by mouth twice daily; - cholecalciferol 25 mcg tabs - daily - every Thursday - 1 tablet orally - nurse to setup seven-day supply in a.m. labeled medibox for resident to self-administer. Take 1 tablet by mouth daily for supplement; - Celexa 25 mg tabs - daily - every Thursday - 1 tablet orally - nurse to setup seven-day supply in a.m. labeled medibox for resident to self-administer for depression; - Aricept 10 mg tabs - daily at bedtime - every Thursday - 1 tablet orally - nurse to setup seven-day supply in p.m. labeled mediboxes for resident to self-administer. Take 1 tablet by mouth daily at bedtime for dementia; - Folic Acid 400 mcg tabs - daily - every Thursday - 1 tablet orally - nurse to setup seven-day supply in a.m. labeled medibox for resident to self-administer. Take 1 tablet by mouth daily for supplement; - lisinopril 10 mg tabs daily - every Thursday - 1 tablet orally - nurse to setup seven-day supply in a.m. labeled medibox for resident to self-administer. Take 1 tablet by mouth daily for hypertension; - Melatonin 3 mg daily at bedtime - every Thursday - 1 tablet orally - nurse to setup	{01770}		

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{01770}	Continued From page 23 seven-day supply in p.m. labeled medibox for resident to self-administer. Take 1 tablet by mouth daily at bedtime for sleep aid; - metoprolol succinate 50 mg daily - every Thursday - 1 tablet orally - nurse to setup seven-day supply in a.m. labeled medibox for resident to self-administer. Take 1 tablet by mouth daily for hypertension; - Zocor 10 mg tabs - daily at bedtime - every Thursday - 1 tablet orally - nurse to setup seven-day supply in p.m. labeled medibox for resident to self-administer. Take 1 tablet by mouth daily at bedtime for hyperlipidemia; and - Vitamin B Complex tabs - daily - every Thursday - 1 tablet orally - nurse to setup seven-day supply in a.m. labeled medibox for resident to self-administer. Take 1 tablet by mouth daily for supplement. On February 25, 2022, at approximately 4:30 p.m., registered nurse (RN)-M stated they have been doing this new process for documentation of medication setup for approximately a month and a half and thought this covered the required documentation requirements. The licensee's Medication Management - Dosage Box Setup policy dated August 1, 2021, noted when the licensed nurse completed medication setup in the dosage boxes, the setup would be documented onto the medication administration record (MAR). No further information was provided.	{01770}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that	{02040}		

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{02040}	Continued From page 24 has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action required.	{02040}		
{02310} SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for two of five residents (R15, R7) with bedrails, with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a	{02310}	On March 1, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of G.	

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	31876	A. BUILDING: _____ B. WING _____	R 02/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOMES OF LAKE C	480 WEST GRANT STREET LAKE CITY, MN 55041

(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
{02310}	Continued From page 25 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). This practice resulted in an immediate correction order related to resident identifier, R15. The findings include: R15 On February 25, 2022, at approximately 12:05 p.m., the surveyor observed registered nurse (RN)-M measure R15's assistive device. R15's bed was equipped with an upside-down U-shaped device located on the right side of a full-size mattress near the head of the bead (HOB). The device was black metal, with a black rubber type material on the top round portion, and both sides went down to the floor. In the middle, there was a 90-degree metal that was slipped between the mattress and frame of the bed. The assistive device was not affixed to the resident's bed. There was a black vinyl pouch 7 inches below the top of the device. The device measured in zone 3, 6 inches from the side of the mattress to the rail and measured side to side between the metal 11 1/8 inches. The device measured 12 inches from the inside top of the device to the bottom of the mattress. R15's Service Plan Agreement dated December 16, 2021, noted services including assistance with activities of daily living and transfers. R15's Side Rail Use Assessment Form dated February 23, 2021, noted "risk factors have been discussed." However, the assessment lacked measurements of the assistive device. On February 25, 2022, at approximately 3:15	{02310}		

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{02310}	Continued From page 26 p.m., RN-B confirmed the side rail use assessment for R15 did not include the assistive device measurements to determine if it was within approved FDA guidelines, as she felt this was a "cane-type" device and not a bedrail. In addition, RN-M stated the measurements of the assistive device would have to have been included on the assessment in order to have an adequate review of the risk versus benefits with the resident or representative. R7 On February 25, 2022, at approximately 11:47 a.m., the surveyor observed RN-M measure R7's bedrails. R7's bed was a hospital bed with bilateral quarter bedrails. The bedrails each had 10 brown metal vertical bars, and the bedrail was affixed to the resident's bed. The right bedrail was noted to be loose and was able to be moved side to side and top to bottom. The openings between the bars for zone 1, measured between 2 inches and 3 5/16 inches. The measurements between the top of the rail to the head of bed for zone 6 measured 2 3/8 inches. Zone 7 measured 9/16 inches. R7's Service Plan Agreement dated December 19, 2021, noted services including escort to and from the dining room, and assistance with activities of daily living. R7's Side Rail Use Assessment Form dated January 10, 2022, noted measurements, but lacked a review of the risk versus benefits with the resident or resident's representative. On February 25, 2022, at 4:06 p.m. president (P)-I, confirmed R7 had not had the risk versus benefits reviewed with R7 or R7's representative.	{02310}		

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{02310}	Continued From page 27 The licensee's Side Rails policy dated August 1, 2021, noted the RN must conduct an assessment to verify the design was consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by communication between licensee, surveyor and review by evaluation supervisor on March 1, 2022, however noncompliance remains at a scope and severity of G.	{02310}		

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{02310}	Continued From page 28 TIME PERIOD FOR CORRECTION: Two (2) days	{02310}		

Electronically Delivered

January 4, 2022

Administrator
Elysian Senior Homes Of Lake C
480 West Grant Street
Lake City, MN 55041

RE: Project Number(s) SL31876015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 2, 2021, 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), immediate fine imposition is authorized for both surveys and investigations conducted. 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 - $500.00

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

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. 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.

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

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

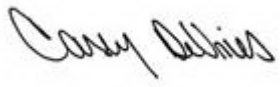
Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. 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
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31876	A. BUILDING: _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL# 31876015 On November 29, 2021, through December 2, 2021, 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 44 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care 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 SUBDIVISION 1-3.	
0 250 SS=F	144G.20 Subdivision 1. Conditions	0 250		

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or 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;	0 250		

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0 250	Continued From page 2 (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, 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, with records 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 29, 2021, at approximately 1:20 p.m., registered nurse (RN)-A, president (P)-I, and corporate RN (CRN)-N stated they viewed the regulations online and in the printed book.	0 250		

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0 250	Continued From page 3 The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), 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 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - In understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data (opens in a new window), the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets the 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	0 250		

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0 250	Continued From page 4 of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in the 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. 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 (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in	0 250		

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0 250	Continued From page 5 new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable. Page five was electronically signed by P-I on May 3, 2021. The licensee had an Assisted Living Dementia Care license, issued on July 20, 2021. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation to and implementation of the assisted living bill of rights - infection control practices - medication and treatment management Refer to licensing order at Statute 144G.90, Subd. 1. The facility failed to provide the proper documentation that a hazard vulnerability or safety risk assessment had been performed on and around the property. This has the potential to affect all dementia care residents. Refer to licensing order at Statute 144G.41, Subd. 3. The licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This deficient practice had the potential to affect the licensee's 44 residents, staff, and visitors. Refer to licensing order at Statute 144G.71., Subd. 2. The licensee failed to ensure the registered nurse (RN) conducted an individualized assessment to determine what medication management services would be provided, and how the services would be	0 250		

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0 250	Continued From page 6 provided for four of four residents (R1, R2, R3 and R4) with record reviewed. Refer to licensing order at Statute 144G.71, Subd. 8. The licensee failed to ensure medications were administered according to manufacturer's instructions for one of two residents (R8) observed with insulin administration via a prefilled insulin pen; failed to ensure medications were administered as prescribed for two of five residents (R8, R2) and failed to ensure documented site of injection for one of two residents (R2) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 9 The licensee failed to ensure documentation of medication setup as required for one of one resident (R7) with record reviewed. Refer to licensing order at Statute 144G.71, Subd. 10. 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, with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 20. The licensee failed to ensure a prescription drug had the original prescription label as required. Refer to licensing order at Statute 144G.71, Subd. 22. The licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R6) upon discharge, with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 3. The licensee failed to develop and	0 250		

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	31876	A. BUILDING: _____ B. WING _____	12/02/2021

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0 250	Continued From page 7 implement a treatment or therapy management plan to include all required content and failed to include a written statement in the service plan of the treatment or therapy service being provided for one of three residents (R3) with records reviewed. In addition, the licensee failed to ensure notification of the registered nurse (RN) for out of range blood sugars for one of two residents (R2) with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 5. The licensee failed to ensure notification of prescriber for out of range blood sugars for one of two residents (R2) with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 6. The licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R3) receiving treatments, with records review. Twenty-nine (29) correction orders were issued, which indicated 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		
0 430 SS=B	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of	0 430		

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0 430	Continued From page 8 license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a copy of the uniform disclosure of assisted living services and amenities (UDALSA) prior to providing assisted living services, for three of four residents (R1, R3 and R4) with records reviewed. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: R1, R3 and R4 began receiving services under the assisted living licensure on August 1, 2021.	0 430		

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0 430	Continued From page 9 R1 R1's Service Plan Agreement dated October 8, 2021, noted services included medication administration and assistance with activities of daily living. On November 30, 2021, at 8:55 a.m., unlicensed personnel (ULP)-B administered medications to R1. R1's Assisted Living with Dementia Care Contract, was dated October 8, 2021, and included the UDALSA being provided at the time the contract was signed, after R1 began receiving services under the assisted living licensure on August 1, 2021. R3 R3's Service Plan Agreement dated August 18, 2021, noted services included medication administration and assistance with activities of daily living. On December 1, 2021, at approximately 11:25 a.m., ULP-E assisted R3 to transfer to his wheelchair for lunch. R4 R4's Service Plan Agreement dated August 28, 2021, noted services included medication administration and assistance with activities of daily living. On November 30, 2021, at approximately 8:38 a.m., ULP-E and ULP-O assisted R4 with morning cares and to transfer with a full body lift into his recliner. On December 2, 2021, at approximately 7:50	0 430		

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0 430	Continued From page 10 a.m., registered nurse (RN)-A and RN-K confirmed all residents that had been admitted prior to August 1, 2021, received the UDALSA at the time of the contract being signed, after they began receiving services under the assisted living licensure. The licensee's Uniform Disclosure of Assisted Living Services & Amenities policy dated August 1, 2021, noted the licensee would provide a UDALSA to prospective residents prior to signing an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
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	0 480		

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0 480	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated November 30, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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.	0 510		

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0 510	Continued From page 12 (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 and current recommendations for COVID-19. This deficient practice had the potential to affect the licensee's 44 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Infection Control: On November 30, 2021, at approximately 7:35 a.m., unlicensed personnel (ULP)-D performed blood glucose monitoring on R8 in his room. ULP-D donned clean gloves, wiped R8's right ring finger with an alcohol wipe and poked it with a lancet to draw blood. A sample of blood was placed on the strip and into the glucometer. ULP-D brought the lancet to the counter in the kitchen and placed it on a paper towel. Without removing gloves or performing hand hygiene, ULP-D brought the insulin pen to R8 and administered the insulin after wiping an area on	0 510		

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0 510	Continued From page 13	0 510		

the lower left quadrant of R8's abdomen. ULP-D brought the pen back to the counter and again placed it on the paper towel. ULP-D began opening cupboards, looking for a glass to put water in, but was unable to locate one. ULP-D opened the refrigerator and removed a bottle of water from the door. After ULP-D administered all medications, she removed her gloves, washed her hands in the sink, wrapped the glucometer, lancet, and insulin pen in the paper towel, and returned to the medication cart. ULP-D unlocked the medication cart and placed the glucometer inside, without cleaning it after use.

On November 30, 2021, at approximately 8:15 a.m., ULP-D verified she had not removed her gloves or performed hand hygiene after performing the blood glucose check and prior to touching multiple surfaces and stated she should have done so. In addition, ULP-D confirmed she had not cleaned the glucometer after use, before placing it in the medication cart, and acknowledged she should have cleaned it with an alcohol wipe after use.

On December 1, 2021, at approximately 2:25 p.m., registered nurse (RN)-A stated staff should wash hands after removing gloves and should clean the glucometer with an alcohol wipe or a Sani wipe after each use.

On November 30, 2021, at approximately 8:38 a.m., ULP-E and ULP-O assisted R4 to get up for the day. ULP-E and ULP-O donned gloves, opened R4's incontinence brief, and ULP-O used a disposable wipe to clean R4's perineal area, which contained stool. ULP-E and ULP-O removed their gloves and threw them into the trash can near the bed. Without performing hand hygiene, ULP-E reached into her front pocket to

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0 510	Continued From page 14 obtain her phone to call the nurse. With direction from the nurse, ULP-E instructed ULP-O to don gloves and to apply a small amount of topical cream to an area on R4's buttocks. After applying the cream, ULP-O removed his gloves and threw them into the trash can. Again, without performing hand hygiene, ULP-O donned another pair of gloves. ULP-O raised R4's catheter bag and passed the catheter bag through R4's pant leg. ULP-O did not remove the gloves. ULP-E finished her phone call and placed the phone next to R4, on the bed sheets. After assisting ULP-O to pull up R4's pants, ULP-E picked the phone up off the bed and placed it in her pocket. Still without performing hand hygiene, ULP-E went into R4's bathroom and pushed the full body lift to the side of R4's bed and removed R4's oxygen tubing from his nose. ULP-E and ULP-O assisted R4 onto the sling, transferred him into the recliner, and ULP-E pushed the full body lift back into the bathroom. ULP-E opened R4's closet, touched the door, hangers, clothes, and then picked up R4's remote control to turn the television on. Without performing hand hygiene, ULP-E donned gloves, changed R4's shirt, applied deodorant, and brushed R4's hair. ULP-E went to the kitchen area of R4's apartment, grabbed a scissors to cut off R4's hospital band, placed R4's call pendant around his neck, and again picked up the remote control. ULP-E and ULP-O removed their gloves and threw them into the trash. Without performing hand hygiene, ULP-O donned new gloves, pushed R4's table next to the recliner, and removed the gloves. Without performing hand hygiene, ULP-E opened the blinds, placed R4's phone on the table, made R4's bed, and touched the light switch. Without performing hand hygiene, ULP-O placed R4's oxygen tubing in his nose. ULP-E continued to tidy the room, touched drawer handles, door handles, light switches, and	0 510		

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0 510	Continued From page 15 while looking for R4's heel protector, reached into her pocket for her phone to use the flashlight. ULP-E tied the plastic garbage bag in the trash can and opened R4's room door. ULP-E and ULP-O walked to the utility room to throw away the bag into the trash bin. ULP-E and ULP-O then went into the laundry room where both ULPs washed their hands. On November 30, 2021, at approximately 9:14 a.m., ULP-E verified she did not perform hand hygiene when changing gloves and stated she always washed her hands before starting personal cares and when she'd completed the cares. On December 2, 2021, at approximately 12:59 p.m., RN-A stated staff should perform hand hygiene as soon as gloves are removed. On November 30, 2021, at 9:15 a.m., ULP-C checked R2's blood sugar and assisted R2 with dressing. After checking R2's blood sugar ULP-C removed gloves and used a phone, which ULP-C pulled out of their pocket. ULP-C then washed hands after using phone, re-applied gloves, removed R2's urine-soaked shirt and incontinent product and cleansed R2 with disposable wipes. With soiled gloves, ULP-C dressed R2, brushed R2's hair, moved the licensee's computer, which ULP-C had brought into R2's room, off of R2's bed and placed the computer onto R2's recliner, stripped R2's urine-soaked bedding off of the bed and then removed gloves. With soiled hands, ULP-C obtained a Boost drink form R2's refrigerator and mixed Miralax (laxative) medication into the Boost. ULP-C walked out of R2's apartment (to go crush medications) carrying the computer, medication cup and two insulin pens. ULP-C washed their hands after	0 510		

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0 510	Continued From page 16	0 510		

placing the two insulin pens into the medication cart and proceeded to crush R2's medications. At that time, ULP-C verified their hands were not washed after checking R2's blood sugar and that gloves were not removed or hands washed after having removed urine-soaked items and providing perineal care to R2.

On December 2, 2021, at 9:10 a.m., RN-A stated gloves should be removed, and hands washed "immediately" after checking a blood sugar, removing urine soaked-items and providing perineal cares.

The licensee's Hand Washing policy dated August 1, 2021, noted hand hygiene should be completed before donning gloves, and after removing the gloves.

EMPLOYEE EYE PROTECTION/FACIAL MASK USE

On November 30, 2021, at 8:29 a.m., maintenance (M)-L walked in the hallway on the memory care unit with no eye protection and with a facemask pulled down below the mouth. Residents were seated in the dining room.

On December 2, 2021, at 1:09 p.m., RN-A stated M-L should wear eye protection and the facial mask should be pulled up over nose and mouth when walking around the facility as M-L "absolutely" may come in contact with a resident out in the hallway.

Minnesota Department of Health (MDH) COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings, dated June 30, 2021, indicated health care workers (HCW's) with face-to-face contact with residents should

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0 510	Continued From page 17 wear medical grade well-fitting facemask and eye protection. MDH guidance titled, Responding to and Monitoring COVID-19 Exposures in Health Care Settings, dated December 8, 2021, indicated to institute universal masking of all health care workers for source control. Universal masking is intended to protect both patients and employees from infected health care workers who may shed virus into the environment before onset of symptoms. Institute use of eye protection (e.g., face shield, goggles) as a way to reduce COVID-19 exposure risk. Eye protection is recommended, at a minimum, for all routine outpatient, acute care, and long-term care encounters when PPE supplies allow. Use of all appropriate PPE can reduce the number of exposures for which exclusion from work is recommended. The licensee's policy, PPE use and Optimization, dated May 5, 2020, indicated PPE consisted of eye protection, facemasks and the licensee would provide HCW's with appropriate PPE according to state and federal guidelines. The licensee's Blood Sugar Testing - Single Equipment Use policy dated August 1, 2021, instructed after obtaining a sample, to clean the glucometer per manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 650	Continued From page 18	0 650		
0 650 SS=C	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for three of three employees (registered nurse (RN)-A, unlicensed	0 650		

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0 650	Continued From page 19 personnel (ULP)-D, and ULP-C) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: RN-A started employment on April 18, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-A's record lacked documented evidence of the following required training: - an overview of the Assisted Living statutes - a review of the provider's policies and procedures - handling of resident complaints, reporting of complaints, and where to report - review of the types of Assisted Living services the employee would provide and the provider's scope of license. ULP-D started employment on April 18, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-D's record lacked documented evidence of the following required training: - an overview of the Assisted Living statutes - a review of the provider's policies and procedures	0 650		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOMES OF LAKE C	480 WEST GRANT STREET LAKE CITY, MN 55041

(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
0 650	Continued From page 20 - review of the types of Assisted Living services the employee would provide and the provider's scope of license. On December 1, 2021, at approximately 1:40 p.m., RN-A and certified facility property manager (CFPM)-H stated the training had been completed for RN-A and ULP-D prior to August 1, 2021, during a staff meeting, but the sign-in sheet had been lost. ULP-C started employment on April 18, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-C's record lacked documented evidence of the following required training: - a review of the provider's policies and procedures - handling of resident complaints, reporting of complaints, and where to report - review of the types of Assisted Living services the employee would provide and the provider's scope of license. On December 1, 2021, at approximately 4:10 p.m., CFPM-H verified ULP-C's record lacked the above required content. The licensee's Employee Records policy dated August 1, 2021, noted the employee record would include records of all training provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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0 680	Continued From page 21	0 680		
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 plan with all of the required content. This had the potential to affect all 44 current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 22 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 29, 2021, at approximately 1:20 p.m., a request was made to view the licensee's emergency preparedness plan, which was provided and later reviewed by surveyors. On November 29, 2021, at approximately 1:50 p.m., a facility tour was conducted with president (P)-I. Emergency exit diagrams were posted outside the elevator on each floor. The emergency preparedness plan was noted in the foyer, and on a table in the commons area for the residents. The licensee's plan lacked identification of the residents' ambulatory status. On December 2, 2021, at approximately 1:00 p.m., certified facility property manager (CFPM)-H confirmed the above required content was not in the binder provided. CFPM-H later produced a list with the required information and placed it in the binder. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, noted the emergency preparedness plan would include all required elements of appendix Z.	0 680		

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0 680	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 690 SS=D	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain permanently recorded records for medication setup for one of one resident (R7) with record 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: The licensee failed to ensure documentation of medications setup in a medication dosage box was recorded permanently and was current at the time of setup.	0 690		

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0 690	Continued From page 24 On November 30, 2021, at 11:33 a.m., registered nurse (RN)-M placed medications into a medication cassette for a one-week supply of medications for the times of 8:00 a.m., 2:00 p.m., 5:00 p.m., and 8:00 p.m., for R7. During the observation, medications were short in supply for the amount needed to setup for the entire week as follows: -divalproex sodium (anti-seizure used for mood stabilization) 125 milligrams (mg) one capsule for 8:00 p.m. dose -donepezil (used to treat dementia) 23 mg one tablet for 8:00 p.m. dose -duloxetine (used to treat depression/anxiety) 60 mg one capsule for 5:00 p.m. dose -memantine (used to treat dementia) 10 mg five tablets for 8:00 p.m. dose -trazodone (used for sleep) 50 mg two tablets for 8:00 p.m. dose Upon completion of the medication setup, RN-M used a pen to sign her initials on a paper medication administration record (MAR) for all seven days from December 7, 2021 through December 13, 2021 for the times noted above. Surveyor inquired with RN-M as to why she documented the placement of the medications in the dosage box for which there was no supply. RN-M stated she should not have signed for setup of the medications for the doses for which there was no supply. RN-M then used Wite-Out to correct the documented areas on the MAR. Surveyor inquired about utilizing correction fluid for documentation changes on the MAR. RN-M stated, "I guess for documentation, I should not have". RN-M stated she should have crossed off the areas documented in error with a pen. On November 30, 2021, at 11:33 a.m., RN-M and surveyor completed a count for accuracy of R7's	0 690		

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0 690	Continued From page 25 remaining lorazepam (controlled substance medication used to treat anxiety) 0.5 mg tablets. Page 179 of the licensee's record book (used for recording counts of controlled substances) indicated lorazepam 0.5 mg take one tablet every two hours as needed (maximum of three doses per day), noted on August 25, 2021, quantity on hand was "90" with "7" tablets used and the quantity that remained was "83". There were no other notations documented. In the presence of the surveyor, RN-M counted the number of tablets inside of R7's lorazepam medication bottle, which revealed 78 tablets. RN-M stated she sets up the lorazepam in a single medication dose box (one week supply of seven tablets total) and that the box was double locked within the medication cart for staff to administer as needed. RN-M checked R7's medication administration record, which indicated staff had administered five doses of lorazepam to R7 since the August 25, 2021, documented notation in the controlled substance record book. RN-M stated she had since set up five more tablets but had not documented the medication setup at the time, which was on November 18, 2021. On November 30, 2021, in the presence of the surveyor, RN-M wrote the date of November 18, 2021, into the book to document the medication setup of the five tablets, and the remaining amount of "78" tablets and requested for RN-K to co-sign for the five tablets previously setup on November 18, 2021, instead of making a notation of late entry. The licensee's policy Resident Record Information and Content, dated August 1, 2021, indicated the licensee would maintain appropriate and accurate records for each resident receiving assisted living services and all entries in the resident records would be permanently recorded with the name and title of the person making the	0 690		

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0 690	Continued From page 26 entry. The policy did not address using correction fluid or documentation errors. The licensee's policy Medication and Treatment, dated August 1, 2021, indicated a licensed nurse would correctly and accurately document any medication setup provided, and the licensed nurse who set up the medication would observe and monitor the past week's medication administration documentation and compliance and would initial to acknowledge it had been done. The policy further indicated the medication regimen would also be updated and reviewed at the time of medication setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 690		
0 730 SS=E	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 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;	0 730		

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0 730	Continued From page 27 (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 status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records contained all records of communication pertinent to resident services for two of four residents (R1, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 730		

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0 730	Continued From page 28 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: R1 R1's record lacked evidence of consistent care for treatment of a skin injury with an outside provider (hospice) or evidence of reporting the change in condition to R1's physician. R1's Service Plan Agreement dated October 8, 2021, noted services included medication administration and assistance with activities of daily living. On November 30, 2021, at 8:55 a.m., ULP-B administered medications to R1. R1 was observed to have geri-sleeves (cloth sleeves used to protect skin) on both lower arms. ULP-C stated the geri-sleeves were intended to help prevent R1 from scratching his skin. R1's record included a hospice plan of care, dated November 2, 2021, which indicated services with hospice registered nurse, social worker and physician. R1's Progress Notes dated October 1, 2021 through November 28, 2021, noted the following: -October 4, 2021, noted over the weekend resident has a large skin tear on right elbow. It was an unwitnessed incident to know how it was obtained. RN instructed staff to apply Vaseline,	0 730		

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0 730	Continued From page 29	0 730		

cover with non-stick dressing and secure in place using Kerlix (bandage roll). Hospice arrived today and RN notified them of the skin tear. Hospice to order geri-sleeves for fragile skin and determine ongoing supplies for dressing changes.
-October 5, 2021, routine RN hospice visit. Dressing intact on right elbow.
-October 7, 2021, wound care, RN removed the Kerlix and non-stick dressing from right elbow. Skin tear 4 centimeters (cm) in diameter. Edges of skin tear are folded down onto the wound bed in some locations. Wound bed is pink with granular tissue. Wound cleaned, Vaseline applied to non-stick dressing and Kerlix to hole in place. Contact hospice to see the plan for treating the wound. RN contacted hospice RN regarding ongoing care of skin tear, and they stated they will care for the wound.
-October 11, 2021, routine hospice nurse visit. There was no documentation regarding the skin tear on R1's right elbow.
-October 19, 2021, routine hospice nurse visit. Scabs to left shin. There was no documentation regarding the skin tear on R1's right elbow.
-October 25, 2021, routine hospice nurse visit. No new skin concerns. There was no documentation regarding the skin tear on R1's right elbow.
-November 1, 2021, routine hospice nurse visit. No skin concerns. There was no documentation regarding the skin tear on R1's right elbow.
-November 11, 2021, routine hospice nurse visit. Scabs on left shin. There was no documentation regarding the skin tear on R1's right elbow.
-November 14, 2021, resident found on floor next to bed. Staff noted a skin tear on right arm. Instructed to cleanse with wound cleanser, apply bacitracin and non-stick dressing, wrapping with Kerlix tight enough to apply pressure to stop the bleeding. Instructed staff to notify hospice. Requested hospice come to access wound from

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0 730	Continued From page 30 fall. -November 15, 2021, fall follow up by RN. Resident did have newly dressed bandage on right forearm. Hospice nurse reported resident had two larger skin tears on his forearm and two smaller ones close together, almost forming one skin tear. Hospice nurse cleaned them, applied bacitracin, applied non-stick dressing and wrapped with Kerlix. Dressing was clean and intact at time RN saw the dressing. RN did request hospice provide a geri-sleeve to prevent future skin tears for this resident. -November 16, 2021, hospice nurse visit. Bleeding from dressing on right arm, new dressing applied. -November 19, 2021, RN changed dressing today. Hospice normally changes these dressings and provides care. The dressing was sliding down and exposing the large moist inner wound. The old dressing consisted of Kerlix that was taped into place with Telfa (guaze wound dresing) underneath. RN noted a moderate amount of red bloody drainage on the dressing. There are a total of five skin tears. The skin was torn away and the wound bed was fresh epithelial tissue. The old skin that was torn from the arm is now dried up. RN cut some of the old skin to make room for the new to form and heal. The wound bed measures 5.3cm x 3.2cm x 0.2cm. It is irregular in shape with bruising around it. The second wound measured 1.3cm x 2cm x 0.1cm. Wound bed with epithelial tissue, edges pulled back. Skin intact with some locations. irregular shape. The third wound measured 4.8cm x 2.2cm x 0.1cm, same looking wound bed and wound edging, including the bruising. Fourth wound measured 1.3cm x 0.6cm x 0.1cm, wound bed growing red epithelial tissue, edges intact, bruising along the inner aspect of wound. The wounds were cleansed with soap, water, and a clean wash rag was used.	0 730		

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0 730	Continued From page 31 Vaseline based gauze was applied to the wounds and covered with Telfa non-stick dressing and wrapped with Kerlix. On left arm large bruise on the upper aspect of the forearm, just below crease of elbow measuring 2 cm x 2.3 cm, very dark red purple in color. Resident also has a skin tear on the back side of that same forearm measuring 1.8cm x 2.6cm x 0.2cm. The wound bed is red with dried blood along the edges of the wound bed. There is some necrotic tissue from the tissue that was ripped during the incident. This wound was also covered with Vaseline gauze, covered with Telfa non-stick dressing and wrapped with Kerlix. RN later applied sleeves to arms to prevent the dressing from sliding and prevent further trauma to arms. -November 23, 2021, routine licensed practical nurse (LPN) visit. Dressings intact on bilateral upper extremities (BUE). Noted skin tears. The licensee's 24-hour alert charting report noted the following: -November 14, 2021, fell, has three skin tears on right arm, hospice called, nurse called, family called, hospice came and checked resident out. -November 15, 2021, documented by RN-M, has multiple skin tears on right forearm. Hospice will be bringing supplies for wound care, including a sleeve to protect. -November 19, 2021, documented by RN-M, dressing changed on both arms. Feel free to change dressing if not intact. Also had sleeves applied. Try to make sure it stays on. Notify nursing if too tight. -November 30, 2021, evening shift, rewrapped arm due to the dressing falling off. No further information was provided for the above noted skin issues, including prescriber's orders or consistent documentation of treatment for the	0 730		

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0 730	Continued From page 32 areas. On December 2, 2021, at approximately 11:55 a.m., RN-M verified R1 continued to have dressings in place for the above noted skin issues. RN-M verified hospice or the licensee's nursing staff was providing the treatment for the above areas. RN-M stated treatment provided by nursing or hospice would be documented in the resident progress notes. RN-A stated there were no prescriber orders for treatment of the above skin issues. R4 R4's record lacked documentation of communication with an outside provider to include signed prescriber orders. R4's Service Plan Agreement dated August 28, 2021, noted services included assistance with activities of daily living. On November 30, 2021, at approximately 8:38 a.m., unlicensed personnel (ULP)-E and ULP-O provided assistance with activities of daily living for R4, including incontinence care, grooming, dressing, transferring, and wound care. R4's record included a hospice plan of care, dated October 1, 2021, which indicated hospice election with skilled nurse, home health aide, medical social worker, chaplain, and massage therapist visits. R4's Progress Note dated October 13, 2021, noted hospice registered nurse (RN) visit with orders received to start prochlorperazine (treat severe nausea) 10 mg (milligrams) tablets twice daily with meals for nausea/vomiting. The note also included, "Continue with current plan of care	0 730		

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0 730	Continued From page 33 and coordinating care with St. Croix Hospice. Awaiting signed copy of orders from Hospice Provider." R4's orders dated October 13, 2021, included prochlorperazine maleate 10 mg one tab orally twice daily for nausea and vomiting; however, lacked prescriber signature. R4's Progress Note dated October 21, 2021, included a "symptom change" due to R4 experiencing nausea and indicated hospice was updated. A new order was received to add another antiemetic (used to relieve nausea) to be given before meals, and the note included, "waiting on medication to arrive and signed copy of orders." R4's orders dated October 21, 2021, included ondansetron (treat nausea) 4 mg disintegrating tablet one tab orally twice daily for nausea/vomiting, administer with scheduled prochlorperazine; however, lacked prescriber signature. R4's Progress Note dated October 24, 2021, indicated a hospice visit with new orders to discontinue metformin (treat type 2 diabetes) 1000 mg tablets. The note indicated the medication was discontinued and removed from the medication cart. R4's orders dated October 24, 2021, included discontinue metformin 1000 mg tablet; however, lacked prescriber signature. R4's Progress Note dated November 3, 2021, indicated order changes to prochlorperazine and fluoxetine (treat depression).	0 730		

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	31876	A. BUILDING: _____ B. WING _____	12/02/2021

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0 730	Continued From page 34 R4's orders dated November 3, 2021, included discontinue prochlorperazine and fluoxetine scheduled orders, and to start fluoxetine 20 mg capsule once daily on November 10, 2021; however, lacked prescriber signature. On December 2, 2021, at 11:46 a.m., RN-K confirmed R4's record lacked signed prescriber orders from hospice, and indicated the process included the hospice nurses would let facility staff know about changes in medications, and would later send a signed order, but "not all the time." RN-K stated, "That didn't happen with these." The licensee's policy Medication and Treatment Orders, dated August 1, 2021, indicated written prescriber's orders would be obtained for any treatment provided to the resident. An order for treatment would contain name of the resident, a description of the treatment to be provide and the frequency, duration, and other information needed to carry out the order. The policy further indicated the licensed nurse would monitor and evaluate treatment orders and services for effectiveness on a regular basis. A resident medication/treatment administration record would be audited regularly by licensed nurse for documentation compliance. The licensee's Resident Record-Information and Content policy dated August 1, 2021, included the resident record would include relevant health records and all records of communications pertinent to the resident's assisted living services. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		

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0 810	Continued From page 35	0 810		
0 810 SS=E	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (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 interview and record review, the facility	0 810		

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0 810	Continued From page 36 failed to provide documentation of 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. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 30, 2021, at approximately 1:00 p.m., during review of fire safety and evacuation records, the licensee's policy lacked documentation of 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. Certified facility property manager (CFPM)-H and director of building and grounds (DBG)-J confirmed they had not documented resident needs for movement or evacuation. A policy related to a plan for 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 was requested, but not available. No further information was provided.	0 810		

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0 810	Continued From page 37 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon	0 900		

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0 900	Continued From page 38 agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for three of four residents (R1, R3, R4) with records 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 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: R1, R3 and R4 began receiving services under the assisted living licensure on August 1, 2021. R1 R1's Service Plan Agreement dated October 8, 2021, noted services included medication administration and assistance with activities of daily living. On November 30, 2021, at 8:55 a.m., unlicensed personnel (ULP)-B administered medications to R1. R1's Assisted Living with Dementia Care Contract was signed October 8, 2021, sixty-nine days after R1 began receiving services under the assisted	0 900		

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0 900	Continued From page 39 living licensure on August 1, 2021. On December 2, 2021, at approximately 11:55 a.m., registered nurse (RN)-M and RN-A verified R1's contract was signed after R1 began receiving services under the assisted living licensure. R3 R3's Service Plan Agreement dated August 18, 2021, noted services included medication administration and assistance with activities of daily living. On December 1, 2021, at approximately 11:25 a.m., ULP-E assisted R3 to transfer to his wheelchair for lunch. R3's Assisted Living with Dementia Care Contract was signed August 18, 2021, eighteen days after R3 began receiving services under the assisted living licensure. R4 R4's Service Plan Agreement dated August 28, 2021, noted service included medication administration and assistance with activities of daily living. On November 30, 2021, at approximately 8:38 a.m., ULP-E and ULP-O assisted R4 with morning cares and to transfer to his recliner. R4's Assisted Living with Dementia Care Contract was signed August 28, 2021, twenty-eight days after R4 began receiving services under the assisted living licensure. On December 2, 2021, at approximately 7:50 a.m., RN-A and RN-K confirmed the contracts	0 900		

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0 900	Continued From page 40 were signed after the residents began receiving services under the assisted living licensure. In addition, RN-A stated all residents that had been admitted prior to August 1, 2021, received and signed the contract after August 1, 2021. The licensee's Signing an Assisted Living Contract policy dated August 1, 2021, noted when a prospective resident was ready to sign a lease and move in, they were to sign two copies of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 930 SS=C	144G.50 Subd. 2 Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;	0 930		

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0 930	Continued From page 41 (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for four of four residents (R1, R2, R3, R4) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R3 and R4 began receiving services under the assisted living licensure on August 1, 2021. R2 began receiving services on August 4, 2021. R1 R1's Service Plan Agreement dated October 8, 2021, noted services included medication administration and assistance with activities of daily living. On November 30, 2021, at 8:55 a.m., unlicensed personnel (ULP)-B administered medications to R1. R1's Assisted Living with Dementia Care Contract was signed October 8, 2021, sixty-nine days after R1 began receiving services under the assisted living licensure. The contract lacked the following required content:	0 930		

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0 930	Continued From page 42 -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer. R2 R2's Service Plan Agreement dated August 4, 2021, noted services included assistance with activities of daily living, medication management and treatment management. On November 30, 2021, at 9:15 a.m., ULP-C assisted R2 with dressing, grooming, personal hygiene and medication administration. R2's Assisted Living with Dementia Care Contract was signed August 4, 2021. The contract lacked the following required content: -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer. R3 R3's Service Plan Agreement dated August 18, 2021, noted services included medication administration and assistance with activities of daily living. On December 1, 2021, at approximately 11:25 a.m., ULP-E assisted R3 to transfer to his wheelchair for lunch. R3's Assisted Living with Dementia Care Contract was signed August 18, 2021, eighteen days after R3 began receiving services under the assisted living licensure. The contract lacked the following required content: -the facility's policy regarding transfer of residents within the facility, under what circumstances a	0 930		

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0 930	Continued From page 43 transfer may occur, and the circumstances under which resident consent is required for a transfer. R4 R4's Service Plan Agreement dated August 28, 2021, noted services included medication administration and assistance with activities of daily living. On November 30, 2021, at approximately 8:38 a.m., ULP-E and ULP-O assisted R4 with morning cares and to transfer to his recliner. R4's Assisted Living with Dementia Care Contract was signed August 28, 2021, twenty-eight days after R4 began receiving services under the assisted living licensure. The contract lacked the following required content: -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer. On December 2, 2021, at approximately 7:50 a.m., registered nurse (RN)-A and RN-K confirmed the contracts lacked the above required content and stated the same contract template was utilized for all residents. The licensee's Signing an Assisted Living Contract policy dated August 1, 2021, lacked information on the content of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		

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0 940	Continued From page 44	0 940		
0 940 SS=C	144G.50 Subd. 2 Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.	0 940		

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0 940	Continued From page 45 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for four of four residents (R1, R2, R3, R4) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R3 and R4 began receiving services under the assisted living licensure on August 1, 2021. R2 began receiving services on August 4, 2021. R1's Service Plan Agreement dated October 8, 2021, noted services included medication administration and assistance with activities of daily living. On November 30, 2021, at 8:55 a.m., unlicensed personnel (ULP)-B administered medications to R1. R1's Assisted Living with Dementia Care Contract was signed October 8, 2021, sixty-nine days after R1 began receiving services under the assisted living licensure. The contract lacked the following required content: -whether the facility had an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); -whether there was a limit on the number of	0 940		

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0 940	Continued From page 46 people residing at the facility who could receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; and -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. R2 R2's Service Plan Agreement dated August 4, 2021, noted services included assistance with activities of daily living, medication management and treatment management. On November 30, 2021, at 9:15 a.m., ULP-C assisted R2 with dressing, grooming, personal hygiene and medication administration. R2's Assisted Living with Dementia Care Contract was signed August 4, 2021. The contract lacked the following required content: -whether the facility had an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); -whether there was a limit on the number of people residing at the facility who could receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; and -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program.	0 940		

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0 940	Continued From page 47 R3 R3's Service Plan Agreement dated August 18, 2021, noted services included medication administration and assistance with activities of daily living. On December 1, 2021, at approximately 11:25 a.m., ULP-E assisted R3 to transfer to his wheelchair for lunch. R3's Assisted Living with Dementia Care Contract was signed August 18, 2021, eighteen days after R3 began receiving services under the assisted living licensure. The contract lacked the following required content: -whether the facility had an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); -whether there was a limit on the number of people residing at the facility who could receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; and -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. R4 R4's Service Plan Agreement dated August 28, 2021, noted services included medication administration and assistance with activities of daily living. R4's Assisted Living with Dementia Care Contract was signed August 28, 2021, twenty-eight days	0 940		

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ELYSIAN SENIOR HOMES OF LAKE C	480 WEST GRANT STREET LAKE CITY, MN 55041

(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
0 940	Continued From page 48 after R4 began receiving services under the assisted living licensure. The contract lacked the following required content: -whether the facility had an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); -whether there was a limit on the number of people residing at the facility who could receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; and -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program. On November 30, 2021, at approximately 8:38 a.m., ULP-E and ULP-O assisted R4 with morning cares and to transfer to his recliner. On December 2, 2021, at approximately 7:50 a.m., registered nurse (RN)-A and RN-K confirmed the contract lacked the above required content, and stated the same contract template was utilized for all residents. The licensee's Signing an Assisted Living Contract policy dated August 1, 2021, lacked information on the content of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		

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01650	Continued From page 49	01650		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (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. 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 four of four residents (R1, R2, R3 and R4) with records reviewed.	01650		

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01650	Continued From page 50 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). The findings include: R1 R1's Service Plan Agreement lacked the following required content: - the schedule of monitoring assessments of the resident; and - a contingency plan that included identification of and information as to who has authority to sign for the resident in an emergency. On November 30, 2021, at 8:55 a.m., unlicensed personnel (ULP)-B administered medications to R1. R1's Service Plan Agreement dated October 8, 2021, noted services included assistance with activities of daily living, medication management, and nurse completion of an annual assessment and an abnormal involuntary movement scale (AIMS) assessment. The Service Plan Agreement also noted all monitoring and reassessment would be completed by a licensed nurse initially and every 90 days thereafter or when there is a change in condition, however the plan lacked identification of the following: - an assessment would be completed for a prospective resident prior to the date on which a prospective resident executed a contract with the facility or the date on which a prospective resident	01650		

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01650	Continued From page 51	01650		

moved in; and
- a reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services.

In addition, the Service Plan Agreement noted for contingency plan "Emergency Contact Information up to date information about who to contact in case of emergency or significant change in condition is documented on page 1 [one] of this document" and listed a person for "Emergency Contact 1"; however, the plan lacked identification of and information as to who had authority to sign for the resident in an emergency.

On December 2, 2021, at approximately 11:55 a.m., registered nurse (RN)-M and RN-A verified R1's Service Plan Agreement lacked the above required content.

R2
R2's Service Plan Agreement lacked the following required content:
- the schedule of monitoring assessments of the resident
- a contingency plan that included identification of and information as to who had authority to sign for the resident in an emergency.

On November 30, 2021, at 9:15 a.m., ULP-C assisted R2 with dressing, grooming, personal hygiene and medication administration.

R2's Service Plan Agreement dated August 4, 2021, noted services included assistance with activities of daily living, medication management, treatment management and nurse completion of an annual assessment. The Service Plan Agreement also noted all monitoring and reassessment would be completed by a licensed

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01650	Continued From page 52	01650		

nurse initially and every 90 days thereafter, or when there is a change in condition, however the plan lacked identification of the following:
- an assessment would be completed for a prospective resident prior to the date on which a prospective resident executed a contract with the facility or the date on which a prospective resident moved in; and
- a reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services.

In addition, the Service Plan Agreement noted for contingency plan "Emergency Contact Information up to date information about who to contact in case of emergency or significant change in condition is documented on page 1 [one] of this document" and listed a person for "Emergency Contact 1"; however, the plan lacked identification of and information as to who had authority to sign for the resident in an emergency.

On December 2, 2021, at approximately 11:20 a.m., RN-M and RN-A verified R2's Service Plan Agreement lacked the above required content.

R3
R3's service plan lacked the following required content:
- a description of the services to be provided
- the schedule of monitoring assessments of the resident.

On December 1, 2021, at approximately 11:25 a.m., ULP-E assisted R3 to transfer to his wheelchair for lunch.

R3's Service Plan Agreement dated August 18, 2021, noted services included medication administration and assistance with activities of

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01650	Continued From page 53	01650		

daily living. In addition, it noted:
- oxygen assist, staff to ensure oxygen set to 3.5 liters at night and to turn off oxygen in the morning. See medication administration record (MAR) for specific instructions.

The Service Plan Agreement also noted all monitoring and reassessment would be completed by a licensed nurse initially and every 90 days thereafter or when there is a change in condition however, the plan lacked identification of the following:
- an assessment would be completed for a prospective resident prior to the date on which a prospective resident executed a contract with the facility or the date on which a prospective resident moved in; and
- a reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services.

R3's prescriber orders dated October 26, 2021, included supplemental oxygen at 2 liters per minute continuously via nasal cannula (prongs placed inside the nostrils) for dyspnea (difficult or labored breathing).

R3's October 2021, medication administration record (MAR) included oxygen at 2 liters per nasal cannula, continuous.

On December 2, 2021, at approximately 7:50 a.m., RN-A and RN-K confirmed R3 received oxygen at 2 liters per minute continuously and verified the service plan lacked the above required content. In addition, RN-A stated the same template was utilized for all residents.

R4
R4's Service Plan Agreement lacked the following

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01650	Continued From page 54 required content: - the schedule of monitoring assessments of the resident. On November 30, 2021, at approximately 8:38 a.m., ULP-E and ULP-O provided R4 assistance with activities of daily living including incontinence care, grooming, dressing, transferring, and wound care. R4's Service Plan Agreement dated August 28, 2021, noted services included assistance with activities of daily living, medication management, and treatment/therapy management. R4's Service Plan Agreement also noted all monitoring and reassessment would be completed by a licensed nurse initially and every 90 days thereafter or when there is a change in condition however, the plan lacked identification of the following: - an assessment would be completed for a prospective resident prior to the date on which a prospective resident executed a contract with the facility or the date on which a prospective resident moved in; and - a reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. On December 2, 2021, at approximately 11:20 a.m., RN-M and RN-A verified R4's Service Plan Agreement lacked the above required content, and verified the same template was used for all residents. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include: - a description of the services to be provided - a schedule and method for the next planned	01650		

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01650	Continued From page 55 assessment and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.	01700		

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01700	Continued From page 56 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment to determine what medication management services would be provided, and how the services would be provided for four of four residents (R1, R2, R3 and R4) with records 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 29, 2021, at approximately 1:20 p.m., registered nurse (RN)-A confirmed the licensee provided medication management services to the licensee's residents. R1, R2, R3 and R4's records lacked evidence the RN had conducted a medication assessment to include: - an identification and review of all medications the resident was known to be taking. R1 R1's Service Plan Agreement dated October 8, 2021, noted services included medication administration and assistance with activities of daily living.	01700		

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01700	Continued From page 57 R1's prescriber orders dated October 1 and 5, 2021, included four medications used to treat pain, one anti-anxiety, one to decrease secretions, one for nausea, three laxatives, one antibiotic, one antipsychotic, one to reduce stomach acid, one to prevent low blood potassium levels, one to treat inflammation and itching of skin, one for wheezing, one to treat allergies, one antidepressant, one to reduce fluid and one corticosteroid (steroid hormone). R1's Medication Assessment and Management Plan dated September 22, 2021, noted "The most accurate list of all medications the client is taking has been reviewed by a nurse including the name of the medication, the dose, the frequency and route of the medication". However, the assessment failed to identify the source of the most accurate list. On December 2, 2021, at approximately 11:55 a.m., RN-M and RN-A verified R1's assessment lacked identification of the medications the resident was known to be taking. R2 R2's Service Plan Agreement dated August 4, 2021, noted services included medication administration, treatment administration and assistance with activities of daily living. R2's Uniform Assessment date signed August 6, 2021, noted "Review of Medications" included, "Indicate name of medication, dosage, frequency and route" and listed the following medications and content: aspirin, atorvastatin (lowers cholesterol), buspirone (antianxiety), donepezil (used to treat dementia), empagliflozin (diabetic), escitalopram (antidepressant), glipizide (diabetic), insulin glargine (diabetic), melatonin (supplement	01700		

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01700	Continued From page 58 used for sleep), metformin (diabetic), pantoprazole (reduces acid) and quetiapine (antipsychotic). The assessment lacked review and identification of indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. Additionally, it lacked identification of interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. R2's Medication Sheet for August 2021, indicated staff administered the above medications. However, the assessment lacked inclusion of the following medications, which were effective August 4, 2021, as noted on the Medication Sheet: docusate sodium (laxative) 100 milligrams (mg) twice daily as needed and quetiapine 25 mg at bedtime as needed. On December 2, 2021, at approximately 11:20 a.m., RN-M and RN-A verified R2's assessment lacked identification of all of the medications the resident was known to be taking. RN-M and RN-A stated there was no other documentation in R2's record for medication assessment beyond the Uniform Assessments provided. R3 R3's Service Plan Agreement dated August 18, 2021, noted services included medication administration and assistance with activities of daily living.	01700		

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01700	Continued From page 59 R3's prescriber orders dated October 15, 2021, included one pain reliever and one statin (used to lower cholesterol). R3's Uniform Assessment dated October 27, 2021, noted "The most accurate list of all medications the client is taking has been reviewed by a nurse including the name of the medication, the dose, the frequency and route of the medication". However, the assessment lacked identification of the source of the most accurate list. R4 R4's Service Plan Agreement dated August 28, 2021, noted services included assistance with activities of daily living, medication management, and treatment/therapy management. R4's prescriber orders dated October 1, 2021, included an antihypertensive, pain relievers, and an antidepressant. R4's Uniform Assessment dated November 9, 2021, indicated "The most accurate list of all medications the client is taking has been reviewed by a nurse including the name of the medication, the dose, the frequency and route of the medication." The assessment lacked identification of the source of the most accurate list. On December 2, 2021, at approximately 7:50 a.m., RN-A and RN-K confirmed the assessment lacked identification of the medications the resident was known to be taking. In addition, they confirmed the same template was utilized for all residents. The licensee's Medication Management -	01700		

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01700	Continued From page 60 Assessment, Monitoring & Reassessment policy dated August 1, 2021, noted the assessment must include an identification and review of all medications the resident was known to be taking. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted reassessment of medications, which included all the required information for one of four residents (R2) with records 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:	01710		

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01710	Continued From page 61 R2's record lacked evidence the RN had conducted a medication reassessment to include an identification and review of all medications the resident was known to be taking. R2's Service Plan Agreement dated August 4, 2021, noted services included medication administration, treatment administration and assistance with activities of daily living. R2's Uniform Assessment dated August 18, 2021, noted "The most accurate list of all medications the client is taking has been reviewed by a nurse including the name of the medication, the dose, the frequency and route of the medication". However, the assessment lacked identification of the source of the most accurate list and lacked a review of contraindications, allergic or adverse reactions, and actions to address these issues. R2's Uniform Assessment dated November 24, 2021, noted, "The most accurate list of all medications the client is taking has been reviewed by a nurse including the name of the medication, the dose, the frequency and route of the medication." However, the assessment lacked identification of the source of the most accurate list. On December 2, 2021, at approximately 11:20 a.m., RN-M and RN-A verified R2's assessment lacked identification of the medications R2 was known to be taking. RN-M and RN-A stated there was no other documentation in R2's record for medication assessment beyond the Uniform Assessments provided. The licensee's Medication Management - Assessment, Monitoring & Reassessment policy	01710		

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ELYSIAN SENIOR HOMES OF LAKE C	480 WEST GRANT STREET LAKE CITY, MN 55041

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01710	Continued From page 62 dated August 1, 2021, noted the assessment must include an identification and review of all medications the resident was known to be taking. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions for one of two residents (R8) observed with insulin administration via a prefilled insulin pen; failed to ensure medications were administered as prescribed for two of five residents (R8, R2) and failed to ensure documented site of injection for one of two residents (R2) with records reviewed.	01760		

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01760	Continued From page 63 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: R2 The licensee failed to follow prescriber orders for insulin and failed to document site for insulin administered by injection. R2's Service Plan Agreement dated August 4, 2021, noted services included assistance with activities of daily living, medication management and treatment management. R2's prescriber orders dated November 17, 2021, included to check blood sugar four times daily (before meals and at bedtime), insulin aspart (Novolog) (fast acting) Flexpen inject 4 units under the skin three times a day with meals. Hold if not eating or eating less than (<) 50 percent and insulin glargine (Lantus) (long acting) inject 10 units under the skin two times a day. R2's Medication Sheet for the month of November 2021, indicated the same. On November 30, 2021, at 9:15 a.m., in the presence of the surveyor and registered nurse (RN)-M, ULP-C checked R2's blood sugar utilizing a glucometer, with result of 263 and administered medication to R2 by injection of	01760		

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01760	Continued From page 64 Lantus insulin 10 units and Novolog insulin 4 units via prefilled insulin pens into R2's left lower abdominal area. After providing services to R2, RN-M pushed R2 in a wheelchair to the main lobby to wait for a ride, as R2 had an outside appointment. R2 left the building without being provided food. ULP-C did not hold the Novolog insulin as prescribed. ULP-C stated at the time, per the nurse, if R2's blood sugar was above 115, staff were to administer the insulin. ULP-C verified she administered the insulin and R2 had not had breakfast before leaving the building for an appointment. In addition, R2's Medication Sheet for the month of November 2021, identified the time of administration, blood sugar results and contained an area for a second signature for the administration of the Novolog and Lantus insulin. The medication sheet did not identify the site (where the insulin was injected into the skin). The website Insulin Routines - American Diabetes Association, indicated Insulin Routines; insulin should be injected into the same general area of the body for consistency, but not the exact same place. Insulin delivery should be timed with meals to effectively process the glucose entering your system. Site Rotation; the place on your body where you inject insulin affects your blood sugar level. Insulin enters the blood at different speeds when injected at different sites. Insulin shots work fastest when given in the abdomen. Insulin arrives in the blood a little more slowly from the upper arms and even more slowly form the thighs and buttocks. Injecting insulin in the same general area (for example your abdomen) will give you the best results from your insulin. Don't inject the insulin in exactly the same place each time, but move	01760		

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01760	Continued From page 65 around the same area. Each mealtime injection of insulin should be given in the same general area for best results. For example, giving your before breakfast injection in the abdomen each day and your before supper insulin injection in the leg each day give more similar blood sugar results. If you inject near the same place each time, hard lumps or extra fatty deposits may develop. Both of these problems make the insulin reaction less reliable. Timing; insulin shots are most effective when you take them so that insulin goes to work when glucose from your food starts to enter your blood. For example, regular insulin works best if you take it 30 minutes before you eat. On December 2, 2021, at approximately 11:20 a.m., RN-M verified ULP-C had administered the Novolog insulin to R2 and that R2 had left the facility for an appointment without eating food. RN-M verified ULP-C had not held the Novolog insulin as prescribed. RN-A and RN-M verified the licensee was not documenting the site of injection. The licensee's policy Medication Management Administration and Setup, dated August 8, 2021, indicated for medication administration the documentation would include the medication name, dosage, date and time administered, and method and route of administration. The licensee's policy Insulin, dated August 1, 2021, indicated insulin medication would be administered according to the prescribers' orders. R8 R8's insulin was not administered according to the manufacturer's instructions. On December 1, 2021, at approximately 7:35	01760		

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01760	Continued From page 66 a.m., unlicensed personnel (ULP)-D performed a blood glucose check and administered insulin to R8. ULP-D dialed the insulin pen to 14, without first priming the pen. R8's Service Plan Agreement dated November 26, 2021, noted services included medication administration and assistance with a shower. R8's prescriber orders dated November 24, 2021, included Basaglar KwikPen (an injectable medication to manage diabetes), 14 units two times a day. R8's November 2021 Medication Sheet listed medications as prescribed, times to administer, and staff initials to indicate the medication had been given, beginning on November 27, 2021. On December 1, 2021, at approximately 2:25 p.m., registered nurse (RN)-A confirmed the insulin pen should have been primed by dialing to two units and ejecting the two units prior to dialing to the prescribed dose. The manufacturer's instruction for the use of the Basaglar insulin pen dated July 2021, instructed to prime the pen before each injection, by turning the dose to 2 units, tapping the cartridge holder gently to collect air bubbles at the top, and pushing the dose knob until it stops and returns to 0. The instructions also indicated not priming the pen prior to each injection may result in too much or too little insulin administered. The licensee's Insulin policy dated August 1, 2021, lacked inclusion of the insulin prefilled pen instructions. No further information was provided.	01760		

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01760	Continued From page 67 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of medication setup as required for one of one resident (R7) with record 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: The licensee failed to ensure documentation for medications setup in a medication dosage box was completed accurately at the time of setup. On November 30, 2021, at 11:33 a.m., registered nurse (RN)-M placed medications into a medication cassette for a one week supply of	01770		

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medications for the times of 8:00 a.m., 2:00 p.m., 5:00 p.m., and 8:00 p.m., for R7. During the observation, medications were short in supply for the amount needed to setup for the entire week as follows:
-divalproex sodium (anti-seizure used for mood stabilization) 125 milligrams (mg) one capsule for 8:00 p.m. dose
-donepezil (used to treat dementia) 23 mg one tablet for 8:00 p.m. dose
-duloxetine (used to treat depression/anxiety) 60 mg one capsule for 5:00 p.m. dose
-memantine (used to treat dementia) 10 mg five tablets for 8:00 p.m. dose
-trazodone (used for sleep) 50 mg two tablets for 8:00 p.m. dose.

Upon completion of the medication setup, RN-M used a pen to sign her initials on a paper medication administration record (MAR) for all seven days from December 7, 2021 through December 13, 2021, for the times noted above. Surveyor inquired with RN-M as to why she documented the placement of the medications in the dosage box for which there was no supply. RN-M stated she should not have signed for setup of the medications for the doses for which there was no supply. RN-M then used Wite-Out to correct the documented areas on the MAR. Surveyor inquired utilizing correction fluid for documentation changes on the MAR. RN-M stated, "I guess for documentation, I should not have." RN-M stated she should have crossed off the areas documented in error with a pen.

On November 30, 2021, at 11:33 a.m., RN-M and surveyor completed a count for accuracy of R7's remaining lorazepam (controlled substance medication used to treat anxiety) 0.5 mg tablets. Page 179 of the licensee's record book (used for

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recording counts of controlled substances) indicated lorazepam 0.5 mg take one tablet every two hours as needed (maximum of three doses per day), noted on August 25, 2021, quantity on hand was "90" with "7" tablets used and the quantity that remained was "83". There were no other notations documented. In the presence of the surveyor, RN-M counted the number of tablets inside of R7's lorazepam medication bottle, which revealed 78 tablets. RN-M stated she sets up the lorazepam in a single medication dose box (one week supply of seven tablets total) and that the box was double locked within the medication cart for staff to administer as needed. RN-M checked R7's medication administration record, which indicated staff had administered five doses of lorazepam to R7 since the August 25, 2021, documented notation in the controlled substance record book. RN-M stated she had since set up five more tablets but had not documented at the time the medication was setup, which was on November 18, 2021.

The licensee's policy Medication Management - Dosage Box Setup, dated August 1, 2021, indicated a licensed nurse would set up resident dosage boxes timely and accurately and when the licensed nurse had completed setting up the medications into the dosage box, the setup was documented on the medication administration record.

The licensee's policy Medication and Treatment, dated August 1, 2021, indicated a licensed nurse would correctly and accurately document any medication setup provided and the licensed nurse who sets up the medications in the dosage box would observe and monitor the past weeks medication administration documentation and compliance and would initial that this had been

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01770	Continued From page 70 done. The policy further indicated the medication regimen would also be updated and reviewed at the time of medication setup. 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 (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	01790		

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01790	Continued From page 71 address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (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, with records reviewed.	01790		

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01790	Continued From page 72 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). The findings include: During the entrance conference on November 29, 2021, at approximately 1:20 p.m., registered nurse (RN)-A confirmed the licensee provided medication management services to residents. The licensee's Medication for Planned Leave of Absence (LOA) competency list, which the licensee identified as the written procedure, lacked information to indicate the RN would conduct a review when the unlicensed personnel (ULP) completed the task to ensure it was completed accurately. The licensee's Medication Management - Planned & Unplanned Time Away policy dated August 1, 2021, noted for unplanned resident time away when the pharmacist or licensed nurse was not available, the RN could delegate this task to the unlicensed personnel (ULP) if the RN had developed written procedures to include a review by the RN of the completion of this task to verify the task had been completed accurately by the ULP. On December 2, 2021, at approximately 2:40 p.m., corporate RN (CRN)-N confirmed the written procedures lacked the above required	01790		

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01790	Continued From page 73 content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a prescription drug had the original prescription label 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 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on November 29, 2021, at approximately 1:20 p.m., registered nurse (RN)-A stated the licensee provided	01890		

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medication management services to the licensee's residents.

On November 30, 2021, at approximately 3:07 p.m., the surveyor completed an observation of the licensee's second floor medication cart and observed the following:
-An unlabeled Lantus SoloStar (used to treat diabetes) insulin pen in the top drawer. The insulin pen lacked a prescription label with the required content. The pen had only a handwritten date of November 26, 2021. ULP-P stated she assumed the insulin pen belonged to R9, but stated, "I cannot tell you because I don't give her insulin." ULP-P stated she assumed the handwritten date indicated the date the insulin pen was opened.

R9's prescriber orders, dated October 11, 2021, included Lantus SoloStar 100 units/milliliters (ml) 29 units subcutaneously (under the skin) daily at 8:15 a.m.

When interviewed on November 30, 2021, at approximately 3:40 p.m., RN-A stated R9's family member (FM)-Q obtained the Lantus SoloStar insulin pens from a charity group in a box, which contained three pens. RN-A stated the licensee kept the box in the medication refrigerator in the medication storage room on the third floor. Upon observation of the box at 3:50 p.m., which contained one additional insulin pen, both the box and the additional insulin pen lacked a prescription label. RN-A verified the insulin should have a prescription label as required.

The licensee's Medications - Prescription Drugs & Prohibition policy, dated August 1, 2021, indicated the prescription medication must be kept in the original container which it was dispensed by the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 75 pharmacy bearing the original prescription label. 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 (R6) upon discharge, with records reviewed.	01910		

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	31876	A. BUILDING: _____ B. WING _____	12/02/2021

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01910	Continued From page 76 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6's record lacked documentation of medication disposition upon R4's discharge from the facility. R6 was discharged on October 29, 2021, after receiving services for diagnoses including worsening dementia and falls. R6's service plan agreement dated September 17, 2021, indicated R6 received services, which included medication administration, assistance with activities of daily living, meals, housekeeping, and laundry. R6's medication administration record (MAR) dated September, 2021 and October, 2021, indicated R6's medications included an antipsychotic, pain relievers, an antianxiety, a psychotropic, an anticonvulsant, and an antihypertensive. R6's discharge summary included a Record of the Inventory and Destruction of Controlled and Uncontrolled Substances, with documentation of three medications destroyed on October 7, 2021, and three medications destroyed on November 2, 2021, but did not include the disposition of all of R6's medications.	01910		

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01910	Continued From page 77 On November 30, 2021, at approximately 3:53 p.m., registered nurse (RN)-A stated all of R6's medications were destroyed upon discharge, but verified the record lacked documentation of it. The licensee's Medication Disposal policy, dated August 1, 2021, indicated upon disposition, the licensee must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;	01940		

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01940	Continued From page 78 (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content and failed to include a written statement in the service plan of the treatment or therapy service being provided for one of three residents (R3) with records reviewed. In addition, the licensee failed to ensure notification of the registered nurse (RN) for out-of-range blood sugars for one of two residents (R2) with records 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:	01940		

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01940	Continued From page 79 During the entrance conference on November 29, 2021, at approximately 1:20 p.m., registered nurse (RN)-K confirmed the licensee provided treatment services to the licensee's residents. R3's record lacked an individualized treatment and therapy management plan to include a statement of the type of services that would be provided. R3's Service Plan Agreement dated August 18, 2021, noted services included medication administration and assistance with activities of daily living. However, R3's service plan lacked identification of a fluid restriction to be provided as ordered. In addition, the service plan included the treatment management plan, which indicated services including the following, but failed to include the fluid restriction: - oxygen assist - Ace wrap - catheter cares. The resident's signed prescriber orders dated October 15, 2021, noted the following: - limit daily fluid intake to 1500 milliliters (ml). On December 2, 2021, at approximately 11:30 a.m., RN-A confirmed R3's service plan and treatment management plan lacked identification of the fluid restriction and stated that it was considered a specialized diet, which the licensee does not provide. In addition, RN-A stated R3's prescriber had not been informed of that. R2 R2's record lacked documented evidence the RN was notified of blood sugars over 400 as directed by the RN.	01940		

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01940	Continued From page 80 R2's Treatment and Therapy Management Plan, dated August 4, 2021, indicated documentation of specific instructions relating to the administration of treatments was located in the resident's electronic medication administration record (MAR)/health record service tasks, on the care plan for the service of blood glucose monitoring. R2's Service Plan Agreement, dated August 4, 2021, included the treatment service of blood sugar check twice daily with instructions to notify the nurse when blood sugars are over 400 and an update dated November 24, 2021, and indicated to notify nurse when blood sugars are below 115 or over 400. R2's Care Plan and Vulnerability and Individual Assessment Plan, dated November 8, 2021, indicated hold Lantus if blood sugar is less than 115 or greater than 450, and call provider. R2's record identified on the following dates blood sugars were recorded to be over 400 for the months of August 2021 through November 2021: -August 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20 (600+), 21, 22, 23, 24, 25, 26, 27, 28 -September 1, 8, 15, 16, 22, 23, 26 -November 6 (9:18 a.m. was 482), 26 (2:34 p.m. was 462, 4:23 p.m. was 455, 6:39 p.m. was 455, 9:02 p.m. was 511, 9:28 p.m. was 511), 28 (10:52 a.m. was 555, 1:59 p.m. was 555, 2:06 p.m. was 479, 4:31 p.m. was 539, 9:35 p.m. was 458) R2's Progress Notes identified the following: -August 21, 2021, blood sugars were over 600 yesterday. RN assessed the resident, blood sugar was 281 this morning and resident denied new symptoms. Insulin was increased two days due to blood sugars running high. -September 27, 2021, blood sugars were noted to	01940		

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01940	Continued From page 81 be running quite high again. Resident has a history of being very unstable with blood sugars, continue to monitor blood sugars and determine causes of hyperglycemia episodes. Notify the provider and determine need for new orders. Received signed orders to increase Lantus and hold for sugar less than 115 and notify doctor for sugar greater than 450. R2's record lacked evidence the RN was notified for the remainder of the out-of-range blood sugars. On December 2, 2021, at approximately 11:20 a.m., RN-M and RN-A stated if there was no documentation in R2's record of notifying the nurse for blood sugars over 400, there was no documentation. The licensee's policy Medication and Treatment Record Documentation and Refusal, dated August 1, 2021, indicated a correct and accurate treatment/therapy record for each resident receiving treatments would be maintained. The licensee's Treatment & Therapy Management Plan policy dated August 1, 2021, noted the service plan and treatment management plan would include a written statement of the treatment or therapy services that would be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments	01960		

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01960	Continued From page 82 Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the prescriber was notified of out-of-range blood sugars for one of two residents (R2) with records 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: R2's record lacked evidence the physician was notified as ordered for blood sugars over 450, as prescribed. R2's Treatment and Therapy Management Plan, dated August 4, 2021, indicated documentation of specific instructions relating to the administration of treatments was located in the resident's	01960		

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01960	Continued From page 83 electronic medication administration record (MAR)/health record service tasks, on the care plan for the service of blood glucose monitoring. R2's Provider Orders, dated October 28, 2021, included to hold Lantus insulin for sugar less than 115. Notify medical doctor for sugar greater than 450. R2's Care Plan and Vulnerability and Individual Assessment Plan, dated November 8, 2021, indicated hold Lantus if blood sugar is less than 115 or greater than 450 and call provider. R2's record identified on the following dates blood sugars were recorded to be over 450: -November 6 (9:18 a.m. was 482), 26 (2:34 p.m. was 462, 4:23 p.m. was 455, 6:39 p.m. was 455, 9:02 p.m. was 511, 9:28 p.m. was 511), 28 (10:52 a.m. was 555, 1:59 p.m. was 555, 2:06 p.m. was 479, 4:31 p.m. was 539, 9:35 p.m. was 458). R2's Progress Notes identified the following: September 27, 2021, blood sugars were noted to be running quite high again. Resident has a history of being very unstable with blood sugars, continue to monitor blood sugars and determine causes of hyperglycemia episodes. Notify the provider and determine need for new orders. Received signed orders to increase Lantus and hold for sugar less than 115 and notify doctor for sugar greater than 450. R2's record lacked evidence the physician was notified of the out-of-range blood sugars. On December 2, 2021, at approximately 11:20 a.m., RN-M and RN-A stated if there was no documentation in R2's record of notifying the physician for blood sugars over 450, there would	01960		

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01960	Continued From page 84 be no documentation elsewhere. The licensee's policy Medication and Treatment Record Documentation and Refusal, dated August 1, 2021, indicated a correct and accurate treatment/therapy record for each resident receiving treatments would be maintained. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R3) receiving treatments, with records review. 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	01970		

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01970	Continued From page 85 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on November 29, 2021, at approximately 1:20 p.m., registered nurse (RN)-K confirmed the licensee provided treatment services to the licensee's residents. R3's record contained a written order by the hospice RN, dated October 26, 2021, for supplemental oxygen at 2 liters per minute continuously via nasal cannula, but lacked a written or electronically recorded order from the prescriber. R3's Service Plan Agreement dated August 18, 2021, noted services included medication administration and assistance with activities of daily living. R3's November 2021, Medication Administration Record, included the order for oxygen as noted above, times to administer, and staff initials to indicate the treatment had been provided. On December 2, 2021, at approximately 7:50 a.m., RN-K confirmed the licensee had not obtained a signed order for the oxygen as required. The licensee's Medication & Treatment Orders policy dated August 1, 2021, noted current, authorized prescriber orders for medications or treatments administered by the staff were kept on file in the resident record. No further information was provided.	01970		

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01970	Continued From page 86 TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide the proper documentation that a hazard vulnerability or safety risk assessment had been performed on and around the property. This has the potential to affect all dementia care 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, 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).	02040		

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02040	Continued From page 87 The findings include: On November 30, 2021, at approximately 1:15 p.m., during record review, the licensee failed to provide evidence of a completed hazard vulnerability assessment. On November 30, 2021, at approximately 1:30 p.m., the certified facility property manager (CFPM)-H and director of building and grounds (DBG)-J confirmed the facility had not yet fully developed the required hazard vulnerability assessment. Global issues such as fire, gas leak, epidemic, and shooter had been identified, but mitigation procedures had not been developed. (CFPM)-H and (DBG)-J further indicated local hazards that are site, building, and population specific, had not been developed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are	02110		

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02110	Continued From page 88 person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. 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).	02110		

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02110	Continued From page 89 The findings include: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. The licensee provided policies for review on September 29, 2021. Upon surveyor review, the following required policy and procedure had not been developed/implemented: -Safekeeping of residents' possessions. On December 2, 2021, at approximately 1:39 p.m., corporate registered nurse (CRN)-N confirmed the licensee did not have a policy as indicated above and stated they did not provide safekeeping of residents' possessions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02160 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (a) In addition to the minimum services required in section 144G.41, an assisted living facility with dementia care must also provide the following services: (1) assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition to the requirements in the licensing rules for the facility. Services must be provided in a person-centered manner that promotes resident choice, dignity, and sustains the resident's abilities; (2) nonpharmacological practices that are	02160		

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02160	Continued From page 90 person-centered and evidence-informed; (3) services to prepare and educate persons living with dementia and their legal and designated representatives about transitions in care and ensuring complete, timely communication between, across, and within settings; and (4) services that provide residents with choices for meaningful engagement with other facility residents and the broader community. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure dignity with the provision of cares, failed to utilize nonpharmacological interventions for behaviors and failed to document behavioral symptoms for changes in psychotropic medications for one of two residents (R2) in the memory care unit, with records 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: DIGNITY The licensee lacked promotion of dignity when providing services to R2 for activities of daily living and medication administration. On November 30, 2021, at 9:15 a.m., registered	02160		

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nurse (RN)-M and unlicensed personnel (ULP)-C assisted R2 with personal hygiene, dressing, grooming, medication administration and treatment administration. R2's shirt, incontinent product, bedding and mattress were wet with urine. RN-M and ULP-C encouraged R2 multiple times to sit up on his bed so R2's shirt could be removed. RN-M stated to R2, "We'll have to cut your shirt off if you don't take it off. We need to keep you safe and that's keeping you safe". While ULP-C proceeded to wash R2's upper body, groin and buttocks with disposable wipes, R2 stated he was "cold" and "it hurt". ULP-C replied to R2, "I know it's cold". After R2 was dressed, ULP-C and RN-M assisted R2 to transfer into a wheelchair. ULP-C obtained crushed medications prepared in applesauce to administer to R2. As ULP-C and RN-M encouraged R2 to take his medications, R2 sat in the wheelchair with his head down. More than one time, RN-M placed the palm of her hand onto R2's forehead and pushed up, to hold R2's head up for ULP-C to administer the medications to R2. R2 did not open his mouth for the medications to be administered when RN-M held his head with the palm of her hand.

On December 2, 2021, at 9:10 a.m., RN-A stated R2 had the right to refuse medications and cares. RN-A stated warm water, wash cloth and towel should have been used for washing R2's body. RN-A stated staff should ensure R2 is safe, walk away and reapproach later or staff could request other staff approach R2 to provide services if R2 was resistive to cares.

NONPHARMALOGICAL INTERVENTIONS/BEHAVIORAL SYMPTOMS
R2's record lacked evidence of non-pharmalogical interventions provided for behaviors and evidence of documented

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02160	Continued From page 92 behavioral symptoms for changes with psychotropic medications. R2's start of care date was August 4, 2021. R2's Uniform Assessment, dated August 4, 2021, indicated a primary diagnosis of Lewy body dementia with history of depression/paranoid/hallucinations. R2 used psychotropic and antipsychotic medications, was often angry and would seek elopement, especially in the evening and nighttime. R2 occasionally needed redirection and had mild disorientation to person, place and time. The assessment indicated conditions that affected R2's responsive behaviors within last six months were: anxiety disorder, Lewy body dementia, hallucinations, pacing and added that R2 often refused cares. The assessment indicated assistance needed to support R2's responsive behaviors included weekly evaluation of behavior management needs by the nurse and cueing and redirection for wandering. The assessment indicated assistance needed to evaluate R2's exit seeking plan included weekly evaluation of behavior management needs by nurse. Protocols in place for R2 included placement of R2's name on elopement risk list, application of appropriate system for elopement, and that R2 would remain within memory care unit, which was locked and secure with staff to monitor needs. R2's Service Plan Agreement, dated August 4, 2021, indicated staff would review care plan daily prior to providing care. Care and wellness assistants were required to provide care and services delegated on the care plan. R2's Care Plan and Vulnerability and Individualized Abuse Prevention Plan, dated	02160		

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02160	Continued From page 93 August 4, 2021, indicated behaviors of wandering and resistiveness to cares. The care plan instructed, if R2 resisted cares, to use music therapy. The plan instructed staff to provide cues and reminders regarding orientation and for staff to monitor and provide for safety. R2's Medication Sheets, dated for the month of August, 2021 indicated the following: Buspar (antianxiety) 30 milligrams (mg) twice daily for anxiety, Lexapro (antidepressant) 10 mg daily, quetiapine (antipsychotic) 50 mg daily and 25 mg at bedtime as needed (PRN) for agitation or difficulty sleeping all effective August 4. Effective August 12 quetiapine 100 mg was changed to give at time of bed. Effective August 19, lorazepam 0.5 mg every two hours as needed (PRN) (max three doses daily). The medication sheets indicated staff had administered two doses of PRN lorazepam and five doses of quetiapine PRN. There were no non-pharmalogical interventions documented as attempted. R2's Progress notes indicated the following: -August 6, 2021, R2 refused multiple staff tasks and told staff to "Fuck off" and "go fuck yourself". -August 12, 2021, staff reported during the night they found R2 sound asleep in bed but that R2's window had been ripped off with just the screen remaining. Staff documented the window was replaced and door alarms were installed on all three windows. Staff documented they contacted R2's provider who increased quetiapine from 25 mg scheduled to 100 mg. The provider also increased the PRN quetiapine from 25 mg to 50 mg. Staff increased safety checks to hourly through the night. R2's Care Plan and Vulnerability and	02160		

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02160	Continued From page 94 Individualized Abuse Prevention Plan, dated August 13, 2021, indicated behaviors of wandering and resistiveness to cares. The care plan instructed, if R2 resisted cares, to use music therapy and that R2 enjoyed cars and watching TV. The plan instructed staff to provide cues and reminders regarding orientation and for staff to monitor and provide for safety. R2's Uniform Assessment, dated August 18, 2021, indicated R2 walked up and down the hallways, tried to open the doors and frequently became very verbally aggressive with staff and to other residents at times. R2 wandered frequently but did not respond to redirection. R2 had a history of becoming confused in the evening and sought to get his truck and return home. The assessment indicated the elopement protocols remained the same and the nurse would conduct weekly evaluation of behavior management needs. R2's Progress notes indicated the following: -August 18, 2021: Increase Lexapro to 10 mg daily, add lorazepam 0.5 mg every two hours PRN agitation (max 3 doses every day) -September 13, 2021, R2 refused medications -September 17, 2021, R2 had been sleeping a lot and was not eating well. Email correspondence on September 20, 2021, indicated RN-M emailed R2's physician an update that R2 had been receiving frequent daily PRN quetiapine and asked the physician if they would recommend adding an additional scheduled dose. Additionally, RN-M noted R2 had not been eating well and had been sleeping more and that when awake, R2 was pacing and very agitated. R2's Provider Orders, dated September 20, 2021,	02160		

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02160	Continued From page 95 included quetiapine 50 mg two tablets (100 mg) twice daily plus one tablet twice daily as needed (PRN) for anxiety/agitation. R2's Progress notes indicated the following: -September 22, 2021, R2 had increased need for quetiapine PRN. RN notified provider to consider scheduling another dose. Provider ordered quetiapine 100 mg twice daily and PRN 50 mg twice daily -September 26, 2021, R2 became agitated and confused, ripped toilet paper holder off wall -September 27, 2021, RN-M visited with R2 about ripping toilet paper holder off wall and about consuming extra sugary foods. RN-M asked R2 if he has been more agitated lately, with people or things getting on his nerves and R2 responded "yes". R2's Behavior Management Plan 2021, dated September 29, 2021, indicated review of the R2's behavior management would be completed including safety checks, scheduled medications and regular activities to help with R2's behavior management. The plan directed all staff to monitor R2 for safety and to assist with redirection. R2's Medication Sheets, dated for the month of September, 2021 indicated the following: Buspar 30 mg twice daily for anxiety, Lexapro 10 mg daily, quetiapine 100 mg changed to give at time of bed and 50 mg once daily PRN for breakthrough anxiety or agitation (non-med interventions play relaxation music, redirect quiet environment, calm approach at client eye level), lorazepam 0.5 mg every two hours as needed (PRN) (max three doses daily). Effective September 21, quetiapine 100 mg twice daily and 100 mg twice daily PRN for anxiety and agitation.	02160		

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02160	Continued From page 96 Effective September 30, quetiapine 100 mg three times a day. The medication sheets indicated staff had administered one dose of PRN lorazepam and five doses of quetiapine PRN. There were no non-pharmalogical interventions documented as attempted. R2's Progress notes indicated the following: -October 26, 2021, R2 had been refusing medications and had been going around the memory unit trying to enter other apartments. R2's Physician Rounding Form, dated October 27, 2021, indicated R2 was more agitated. Orders included to discontinue quetiapine 100 mg tablets, start quetiapine 300 mg twice daily scheduled and one dose PRN (increase) anxiety/agitation (spread quetiapine doses minimum 4 hours apart, but ok to give with lorazepam or 1 hour apart from tramadol PRN), discontinue lorazepam 0.5 mg, start lorazepam 1 mg tablet twice daily scheduled and one dose daily PRN (increase) (can give at same time as scheduled) for anxiety or agitation, start tramadol 50 mg twice daily scheduled and one dose daily PRN (can give at same time as scheduled tramadol, but spread 1 hour from PRN lorazepam/quetiapine) for pain/agitation. OK to give scheduled doses at same time. Discontinue Buspar 10 mg tablet. R2's Progress notes indicated the following: -October 28, 2021, R2 was "snowed today", since starting the new medications. Staff stated R2 was slouched over and was not responding to them. RN assessed. Provider notified of sedation. Email correspondence on October 28, 2021, indicated RN-M sent an email to R2's physician to communicate R2 was completely "snowed" with	02160		

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02160	Continued From page 97 change in medications from the day prior and asked the physician if the medications should have been added one at a time. R2's Provider Orders, dated October 28, 2021, included lorazepam 1 mg tablet, take one tablet twice daily scheduled plus 1 tablet every day PRN anxiety or agitation (can give at same time as scheduled dose, hold scheduled dose if sedated), quetiapine 300 mg tablet take one half tablet (150 mg) twice daily (decrease) plus 1 tablet every day PRN anxiety/agitation (spread quetiapine doses minimum 4 hours apart, but ok to give with lorazepam or 1 hour apart from tramadol PRN) and tramadol 50 mg tablet take 1 tablet three times a day (increase) PRN pain/agitation (ok to give with other tramadol, spread PRN tramadol from PRN lorazepam/ quetiapine by 1 hour). OK to give scheduled doses at same time. R2's Progress notes indicated the following: -October 29, 2021, R2 was an uncontrolled diabetic, often had behaviors such as kicking on doors to other resident apartments, entered other resident rooms, hollered, and refused medications and cares. The note further referenced recent email communication with R2's physician and medication changes that were made due to R2 being sedated. Email correspondence on October 29, 2021, indicated RN-M sent an email to R2's physician informing that R2 fell twice without injury and due to R2 not eating much the day prior because of sedation, R2's blood sugar had dropped to the mid 40's overnight. RN-M informed that R2 was currently sitting up on the end of his bed, which was a huge improvement from the day before. RN-M notified R2 had been combative and hollered at staff about getting out to find his car.	02160		

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02160	Continued From page 98 RN-M reported she assessed R2 and instructed staff that metformin, glipizide, Lantus and quetiapine all be given only with nursing discretion and that RN-M had placed R2's Lantus on hold. R2's Provider Orders, dated October 29, 2021, included hold metformin and glipizide for blood sugars less than 115, check blood sugars three times a day before insulin and metformin/glipizide doses, Tylenol 500 mg take 1 tablet three times a day PRN for pain or fever. R2's Progress notes indicated the following: -October 30, 2021, RN-R noted resident had multiple medication and dosage changes for continuing aggression and combative behavior that was difficult to redirect. R2 refused to get up out of bed or take medications, kept repeating "too cold" and would not open eyes. RN-R assisted R2 to a seated position on the edge of bed after multiple attempts. R2 continued to hold arms folded tight across chest with eyes closed, was offered multiple food choices but voiced that everything was "too cold". R2 was able to carry on conversation about racing motorcycle and mustang car and ate three bites of salad and cake. The note further indicated R2's spouse visited and R2 ate a small amount of chicken, fries and apple pie. Email correspondence on October 31, 2021, indicated RN-R sent an email to R2's physician indicating R2 had not received any quetiapine or lorazepam scheduled or PRN since the evening of Friday October 29, 2021, due to being very difficult to arouse for meals/cares and wanting to sleep all the time. RN-R reported R2 had been more awake and alert today even with low blood glucose and that R2 had been very unpredictable	02160		

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02160	Continued From page 99 to whether or not he would eat. R2's Provider Orders, dated October 31, 2021, included lorazepam 1 mg tablet, take one tablet three times daily scheduled (increase) plus 1 tablet every day PRN anxiety or agitation (can give at same time as scheduled dose), quetiapine 300 mg tablet take one half tablet (150 mg) three times daily scheduled (increase) plus 1 tablet every day PRN anxiety/agitation (spread doses minimum 4 hours apart) and tramadol 50 mg tablet take one half tablet three times a day scheduled plus one half tablet every day PRN (decrease) pain/agitation (ok to give with other tramadol, spread PRN tramadol from PRN lorazepam/ quetiapine by 1 hour). R2's Medication Sheets, dated for the month of October, 2021 indicated the following: Buspar 30 mg twice daily for anxiety, Lexapro 10 mg daily, quetiapine 100 mg three times a day and 100 mg twice daily PRN, lorazepam 0.5 mg every two hours as needed (PRN) (max three doses daily). Effective October 27, quetiapine 300 mg twice daily and 300 mg daily PRN, lorazepam 1 mg twice daily for anxiety/agitation and lorazepam 1 mg daily PRN. Effective October 28, quetiapine 75 mg twice daily. Non-medication interventions were to play relaxation music, redirect to quiet environment, calm approach at R2's eye level. The medication sheets indicated staff had administered two doses of PRN lorazepam and one dose of quetiapine PRN. There were no non-pharmalogical interventions documented as attempted. R2's Progress notes indicated the following: -November 2, 2021, RN-R noted she an had sent email to R2's physician addressing R2 not having any quetiapine or lorazepam since October 29,	02160		

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2021, due to being difficult to arouse for meals/cares and wanting to sleep all the time. RN-M noted orders were received on October 31, 2021, but indicated the orders were not processed at that time due to R2 continuing to have problems with hypoglycemia and the orders would be on hold until R2 was seen by provider on November 3, 2021.

A physician order sheet, dated November 3, 2021, included orders to address diabetes. RN-M had sent a note with R2 to the appointment updating of R2's change in condition and medicaion changes. The note indicated R2 had not been having any behaviors.

R2's Progress notes indicated the following:
-November 4, 2021, staff reported R2 woud not wake up to take medications. Medications were held.

The licensee's 24-hour Alert Charting Report dated November 5, 2021, indicated staff removed R2 from another room at 3:00 a.m.

Email correspondence on November 5, 2021, at 11:01 a.m., indicated RN-M sent an email to R2's physician informing that due to so much going on with R2 including medications, blood sugars and sedation, nursing staff sent R2 in to clinic on November 3, 2021. RN-M updated the physician that R2 started back on Metformin, Lantus, scheduled lorazepam 1 mg twice daily and quetiapine 150 mg twice daily. RN-M reported, by the next day, R2 was so sedated again that he was not able to wake up to take his medications and although R2 later started to wake up, he had not taken any medicaitons, eating was very minimal and R2 had exhibited no behaviors. R2's physician responded vial email at 9:19 p.m., to

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place R2 on a "medication holiday", to hold the psychotropic medications for several days then bring them back slowly.

Provider orders dated November 5, 2021, noted by RN-M on November 8, 2021, included hold lorazepam and quetiapine scheduled doses times two days then resume at lorazepam 0.5 mg twice daily and quetiapine 75 mg twice daily scheduled.

The licensee's 24-hour Alert Charting Report dated November 6, 2021, indicated night shift reported R2 had been up since 11:00 p.m., and had been wandering the halls. On November 7, 2021, day shift staff reported they could not wake R2 and that he would not sit up or have breakfast. R2 was mumbling and medications were held. Evening shift reported R2 was lethargic at supper and did not eat. Staff pushed fluids.

R2's Care Plan and Vulnerability and Individualized Abuse Prevention Plan, dated November 8, 2021, indicated behaviors of wandering and resisting cares. The care plan instructed if R2 resisted cares to use music therapy and that R2 enjoyed cars and watching TV. The plan instructed staff to provide cues and reminders regarding orientation and for staff to monitor and provide for safety.

Email correspondence on November 9, 2021, indicated RN-M sent an email to R2's physician informing that the PRN quetiapine and PRN lorazepam were still ordered at the higher doses of 300 mg PRN and 1 mg daily PRN, respectively. R2's physician responded that they meant to adjust the PRN's as well as the scheduled medications and would send new orders soon.

The licensee's 24-hour Alert Charting Report

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02160	Continued From page 102 dated November 6, 2021, indicated evening shift reported R2 was being very disruptive, then laid down in the sunroom and took a nap. R2 had refused medications. On November 11, 2021, the evening shift reported R2 ate very well for supper and took 5:30 p.m. medications with no issues. R2 started getting agitated and combative around 8:00 p.m. Staff documented they got R2 to take his medications including a dose of quetiapine taken out of the next day's scheduled medications, per nursing's request. Provider orders dated November 12, 2021, included lorazepam 0.5 mg twice daily and quetiapine 75 mg twice daily scheduled, lorazepam 0.5 mg twice daily PRN anxiety/agitation in addition to the scheduled doses and quetiapine 75 mg twice daily PRN anxiety/agitation in addition to the scheduled doses. Alternate PRN lorazepam and quetiapine. Spread medication doses by at least 1 hour. The licensee's 24-hour Alert Charting Report dated November 14, 2021, indicated R2 was acting very inappropriate towards staff when giving insulin. On November 17, 2021 day shift indicated they sent R2 to the emergency room and R2 would be admitted. R2's Progress notes indicated the following: -November 17, 2021, staff reported R2 had been incontinent of stool off and on for a couple of weeks and had a very loose, "explosive" stool, which was unusual for R2. Staff documented they sent a message to R2's physician regarding R2's condition over last two weeks, and that R2 had had appointment scheduled that day, but due to wife unable to transport, staff sent R2 to the emergency room.	02160		

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02160	Continued From page 103 R2's Medication Sheets, dated for the month of November, 2021 indicated the following: Lexapro 10 mg daily, quetiapine 75 mg twice daily and 300 mg daily PRN, lorazepam 1 mg twice daily for anxiety/agitation and lorazepam 1 mg daily PRN. Effective November 10, quetiapine 75 mg twice daily, lorazepam 0. 5 mg give one half tablet twice daily. Effective November 12, lorazepam 1 mg give one-half tablet twice daily and quetiapine 75 mg twice daily PRN. Non-medication interventions were to play relaxation music, redirect to quiet environment and calm approach at R2's eye level. The medication sheets indicated staff had administered one dose of PRN lorazepam and one dose of quetiapine. There were no non-pharmalogical interventions documented as attempted. R2's hospital After Visit Summary indicated the hospital admitted R2 on November 17 and discharged R2 on November 24, 2021. R2's principal diagnosis was failure renal acute (acute kidney injury) and medication orders included to discontinue tramadol, lorazepam., Metformin and glipizide. Orders also included Lexapro 10 mg daily, quetiapine 25 mg take three tablets (75 mg) two times a day and two tablets (50 mg) two times a day PRN for agitation or difficult sleeping (not within three hours of previously receiving given quetiapine dose). R2's Uniform Assessment, dated November 24, 2021, indicated R2 was often angry and would seek elopement, especially in the evening and a nighttime. R2 had behaviors (behavioral management plan indicated), exhibited wandering, was physically abusive, socially inappropriate and had disruptive behaviors that negatively impacted other residents or others in the facility. The assessment indicated the facility	02160		

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02160	Continued From page 104 RN had consulted with R2's physicians to provide medications to help with calming R2. The assessment further indicated R2 often refused cares, became very verbally aggressive with staff and residents at times, had attempted to seek exits, however, had not had a successful elopement. The assessment detailed R2 had frequently attempted to leave through doors and windows of the facility and did not respond to redirection. The assessment indicated the nurse conducted weekly evaluation of R2's behavior management needs and that R2 used antipsychotic medication, quetiapine 75 mg BID for targeted symptoms of behavioral issues, anger, exit seeking, verbal. Non-pharmalogical approaches listed were redirection to a quiet environment, talk to R2 about cars or motorcycles. The assessment indicated non-pharmalogical approaches were effective and a gradual dose reduction had been attempted since the last assessment. The writer of the note concluded it was likely that R2's behaviors would return due to his diagnosis and indicated a nursing diagnosis of: problem of anger related to Lewy body dementia evidenced by elopement attempts, kicking doors and attempting to remove windows. R2's Service Plan Agreement, dated November 24, 2021, instructed staff to review R2's care plan daily prior to providing care. Care and wellness assistants were required to provide care and services delegated on the care plan. R2's Care Plan and Vulnerability and Individualized Abuse Prevention Plan, dated November 24, 2021, indicated behaviors of wandering and resistiveness of cares. If R2 resisted cares to use music therapy, and that R2 enjoyed cars and watching TV. The plan	02160		

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02160	Continued From page 105	02160		

instructed staff to provide cues and reminders regarding orientation and for staff to monitor and provide for safety.

The licensee's 24-hour Alert Charting Report dated November 25, 2021, indicated R2 was very combative, all insulins were held due to not eating anything, and all 9:00 p.m. medications were held due to R2 being combative and refusing everything. Staff documented they notified nursing and encouraged R2 to eat and drink. On November 26, 2021, night shift staff indicated R2 came out of his room a little after 4:00 a.m., was confused and resistant to help. Evening shift indicated R2 exhibited behaviors, was aggressive, hitting and screaming. On November 27, 2021, night shift indicated they administered PRN quetiapine for agitation, per nursing. On November 28, 2021, evening shift indicated R2 tried to hit and kick when medication administration was attempted. On November 29, 2021, night shift indicated R2 had been up and down in his room all night.

R2's Medication Sheets, dated for the month of November, 2021 indicated the following: Lexapro 10 mg daily, quetiapine 75 mg twice daily and 300 mg daily PRN, lorazepam 1 mg twice daily for anxiety/agitation and lorazepam 1 mg daily PRN. Effective November 10, quetiapine 75 mg twice daily, lorazepam 0. 5 mg give one half tablet twice daily. Effective November 12, lorazepam 1 mg give one-half tablet twice daily and quetiapine 75 mg twice daily PRN. Non-medication interventions were to play relaxation music, redirect to quiet environment and calm approach at R2's eye level. The medication sheets indicated staff had adminisered one dose of PRN lorazepam and one dose of quetiapine PRN. There were no non-pharmalogical interventions

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02160	Continued From page 106 documented as attempted. R2's record lacked documented evidence that non-pharmalogical interventions were attempted for behavioral symptoms to determine effectiveness (other than as noted above on October 30, 2021 by RN-R), and R2's record lacked evidence of consistently documented behaviors to determine if changes in medications were needed as noted above. In addition, R2's record lacked evidence of weekly evaluation of behavior management needs by the nurse as indicated on Uniform Assessments dated prior to November 24, 2021. On December 1, 2021, at 10:05 a.m., RN-A stated behaviors would be documented in progress notes when R2 had behaviors. RN-A stated R2 has not had behaviors in a long time. On December 1, 2021, at 1:11 p.m., RN-M stated R2 exhibited behaviors such as threatening staff, hitting and kicking staff and added that other residents were fearful of R2. R2 kicked other resident doors and tried to go into other resident's rooms. RN-M verified the above changes in psychotropic medications. RN-M stated she communicated with R2's physician by email. On December 2, 2021, at approximately 11:20 a.m., RN-M and RN-A stated R2's behaviors and any non-pharmalogical interventions that had been attempted would be documented in the progress notes or on the 24-hour report. The licensee policy Dementia Care Philosophy, dated August 1, 2021, indicated the licensee's philosophy begins with a high standard for enhancing the quality of life and dignity of older adults. Quality of life means supporting aging with	02160		

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02160	Continued From page 107 choice, empowering our residents, and providing them with options. The licensee's policy Behavioral Symptoms, Interventions and Nonpharmalogical Approaches, dated August 8, 2021, indicated the licensee supports person centered and evidenced based evaluations of behavioral symptoms and design of supports for intervention plans, including nonpharmalogical interventions or practices in the following ways: RN completes behavior management plan and evaluates, and updates based on resident needs. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02160		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and	02170		

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02170	Continued From page 108 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 review, the licensee failed to ensure an individualized activity plan was developed for two of two residents (R1, R2) with records 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: The facility had an assisted living with dementia care license, effective August 1, 2021.	02170		

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02170	Continued From page 109 The licensee lacked an individualized activity plan for R1 and R2 based on their evaluation for activities. R1 R1's diagnoses included symptoms and signs involving cognitive functions and awareness. R1's Activity Evaluation, dated October 1, 2021, addressed the required areas and indicated R1 was interested in watching any farm/tractor show, anything that included farming or farming equipment, pastor visits, walking, music, going outside with staff within the memory care unit patio. R1 enjoyed hand massages, holding his cat, and needed redirection due to dementia. R1 required assist of one to walk with a walker and was easily distracted. Adaptations to participate were to use one-to-one approach and speak slow. The evaluation indicated to use R1's cat to assist to get to meals and activities, and to minimize behavioral symptoms were pet visits, petting his cat and watching television, especially shows with tractors. R1's record lacked development of an individualized activity plan based on R1's activity evaluation. On December 2, 2021, at approximately 11:55 a.m., RN-M and RN-A verified R1's record lacked development of an individualized activity plan based on R1's activity evaluation. R2 R2's diagnoses included dementia with Lewy bodies. R2's Activity Evaluation, dated October 4, 2021,	02170		

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02170	Continued From page 110 addressed the required areas and indicated R2 was interested in cars, sports, motorcycles, car or sport magazines, pastor visits, going outside, talking about cars and motorcycles. R2 required minimal assistance to participate in activities and listed current limitations to participate in activities as depression, anxiety and dementia. Adaptations to participate were car shows, sport shows, car magazines and activities to minimize behavioral symptoms were walks, magazines and television shows. R2's record lacked development of an individualized activity plan based on R2's activity evaluation. On December 2, 2021, at approximately 11:20 a.m., RN-M and RN-A verified R2's record lacked development of an individualized activity plan based on R2's activity evaluation. The licensee's policy ALDC Life Enrichment Programs, Activities and Outdoor Space, dated August 1, 2021, identified the licensee was an Assisted Living with Dementia Care licensed facility and an individualized activity plan would be developed for each resident based on their evaluation. The plan would reflect the resident's activity preferences and needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the	02240		

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02240	Continued From page 111 resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why	02240		

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02240	Continued From page 112 an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a written acknowledgment of receipt of the current assisted living bill of rights was obtained prior to initiating services for three of four residents (R3, R4, R1) with records reviewed. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R3 and R4 began receiving services under the assisted living licensure on August 1, 2021. R1 R1's Service Plan Agreement dated October 8, 2021, noted services included medication administration and assistance with activities of daily living. R1's Assisted Living with Dementia Care Contract included the Minnesota Bill of Rights for Assisted Living, with a written acknowledgement dated October 8, 2021, sixty-nine days after R1 began receiving services under the assisted living licensure. On November 30, 2021, at 8:55 a.m., ULP-B administered medications to R1.	02240		

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02240	Continued From page 113 R3 R3's Service Plan Agreement dated August 18, 2021, noted services included medication administration and assistance with activities of daily living. R3's record contained the Minnesota Bill of Rights for Assisted Living, with a written acknowledgement dated August 18, 2021, eighteen days after R3 began receiving services under the assisted living licensure. On December 1, 2021, at approximately 11:25 a.m., unlicensed personnel (ULP)-E assisted R3 to transfer to his wheelchair for lunch. R4 R4's Service Plan Agreement dated August 28, 2021, noted services included assistance with activities of daily living, medication management, and treatment/therapy management. R4's record contained the Minnesota Bill of Rights for Assisted Living, with a written acknowledgement dated August 28, 2021, twenty-eight days after R4 began receiving services under the assisted living licensure. On November 30, 2021, at approximately 8:38 a.m., ULP-E and ULP-O provided assistance with activities of daily living for R4, including incontinence care, grooming, dressing, transferring, and wound care. On December 2, 2021, at approximately 7:50 a.m., registered nurse (RN)-A and RN-K confirmed the Bill of Rights was provided with the contract, which was dated August 18, 2021. In addition, RN-A stated all residents that had been admitted prior to August 1, 2021, received the Bill of Rights at the time of the contract being signed, which would be after they began receiving	02240		

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02240	Continued From page 114 services under the assisted living licensure. The licensee's Bill of Rights policy dated August 1, 2021, noted the licensee would provide the resident or the resident's representative a written copy of the Assisted Living Bill of Rights before the date that services were first initiated. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02310 SS=E	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for three of four residents (R1, R3 and R4) with bedrails, one of one resident (R3) with oxygen storage, and one of two residents (R4) with catheter placement during cares, with records 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 a pattern scope (when more than a	02310		

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02310	Continued From page 115 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: BEDRAILS R1 On November 30, 2021, at 8:55 a.m., the surveyor observed ULP-B administer medications to R1. R1 laid in bed and the surveyor noted the bed to have stationary upper bedrails in the upright position on both sides of the bed. R1's Service Plan Agreement dated October 8, 2021, noted services included medication administration and assistance with activities of daily living. R1's Side Rail Use Assessment Form, dated October 7, 2021, noted R1 utilized the rails to promote independence. The assessment included a section noting the siderail design was consistent with the Food and Drug Administration (FDA) 2006 recommended dimensional measurements to reduce entrapment, and the distance of space must not exceed 4.75 inches in the space between the parameters of the rail, under the rail between the rail supports or next to the single rail, or between the rail and the mattress. However, the assessment lacked documentation of R1's bedrail measurements. On December 2, 2021, at 10:41 a.m., RN-M verified she had not measured R1's bedrails as a part of her assessment. The surveyor observed RN-M measure R1's bedrails, which were found to be within the FDA recommended dimensional	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31876	A. BUILDING: _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOMES OF LAKE C	480 WEST GRANT STREET LAKE CITY, MN 55041

(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
02310	Continued From page 116	02310		

measurements. Between the rails measured between 2 to 3.5 inches, and from the inside of the rail to the mattress measured 2.25 inches.

R3
On December 1, 2021, at approximately 11:25 a.m., the surveyor observed unlicensed personnel (ULP)-E assist R3 to transfer to his wheelchair for lunch. The surveyor noted R3's bed had stationary upper bedrails in the upright position on both sides of the bed.

R3's Service Plan Agreement dated August 18, 2021, noted services included medication administration and assistance with activities of daily living.

R3's Side Rail [bedrail] Assessment Form dated November 2, 2021, noted R3 utilized the rails to promote independence. The assessment included a section noting the siderail design was consistent with the Food and Drug Administration (FDA) 2006 recommended dimensional measurements to reduce entrapment, and the distance of space must not exceed 4.75 inches in the space between the parameters of the rail, under the rail between the rail supports or next to the single rail, or between the rail and the mattress. However, the assessment lacked documentation of R3's bedrail measurements.

On December 2, 2021, at approximately 7:50 a.m., registered nurse (RN)-K confirmed she had not measured any of the resident bedrails as a part of her assessment. At approximately 11:00 a.m., RN-K measured R3's bedrails, were found to be within the FDA recommended dimensional measurements. Between the rails measured between 2.5 to 3.5 inches, from the head of the bed to the top of the mattress measured 1.0 inch,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31876	A. BUILDING: _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOMES OF LAKE C	480 WEST GRANT STREET LAKE CITY, MN 55041

(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
02310	Continued From page 117 and from the rail to the mattress measured 1.0 inch. R4 On November 30, 2021, at approximately 8:38 a.m., the surveyor observed ULP-E and ULP-O assist R4 with incontinence care, grooming, dressing, transferring, and wound care. The surveyor noted R4's bed had stationary upper bedrails in the upright position on both sides of the bed. R4 was dependent on ULP-E and ULP-O for turning from side to side in the bed and was not observed to use the side rails for bed mobility. R4's Service Plan Agreement dated August 28, 2021, noted services included assistance with activities of daily living. R4's record included a Physical Device Assessment, dated November 12, 2021, which indicated R4 needed side rails, low bed, hospital bed, walker wheelchair, and bed/chair alarm due to enhancement and maximization to participate in cares and to optimize independence. Although R4's record included a Risk Agreement, signed by R4 on November 2, 2021, R4's record lacked evidence a bed rail assessment had been completed. On December 2, 2021, at approximately 10:49 a.m., RN-K confirmed she had not completed a side rail assessment and had not measured the side rails to ensure safety. The surveyor observed RN-K measure R4's side rails, which were found to be within the FDA recommended dimensional measurements. Measurements included 1.5 to 2 inches between the mattress and the side rail on each side of the bed. From	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31876	A. BUILDING: _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOMES OF LAKE C	480 WEST GRANT STREET LAKE CITY, MN 55041

(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
02310	Continued From page 118 the head of the bed to the top of the mattress measured 0.5 inches, and between each rail measured 3.5 inches. The licensee's Side Rails policy dated August 1, 2021, noted the RN must conduct an assessment to verify the design was consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". OXYGEN STORAGE On November 30, 2021, at approximately 8:40 a.m., the surveyor observed R3 in his room, sitting in the recliner. The room contained seven oxygen tanks in a black plastic holder on the floor, and eight oxygen tanks, which were standing upright on the floor, not in a holder, or supported.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31876	A. BUILDING: _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOMES OF LAKE C	480 WEST GRANT STREET LAKE CITY, MN 55041

(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
02310	Continued From page 119 On December 2, 2021, at approximately 11:00 a.m., RN-K stated expected all portable oxygen tanks to be placed in a holder. The licensee's Oxygen policy dated August 1, 2021, noted oxygen cylinders must remain upright at all times. Minnesota Department of Health's Oxygen Cylinder Storage Requirements document dated April 16, 2020, noted the cylinders must be secured with chains or racks. CATHETER PLACEMENT On November 30, 2021, at approximately 8:50 a.m., the surveyor observed ULP-E and ULP-O prepare to transfer R4 with a full body lift, into his recliner for breakfast. ULP-O raised R4's catheter bag at least 18 to 24 inches above the bed and passed the catheter bag through R4's pant leg. ULP-E and ULP-O assisted R4 onto the lift sling whereupon ULP-E hooked the catheter bag onto the lift, approximately 24 to 30 inches above R4, and transferred R4 into the recliner. ULP-E hung the catheter bag on the side of the recliner. On November 30, 2021, at approximately 9:14 a.m., ULP-E stated she was taught to never lift the catheter bag above the resident's bladder; however, indicated she didn't know where to hang it during the transfer to keep it out of the way. On December 2, 2021, at approximately 12:59 p.m., RN-A verified staff should not raise the catheter bag above the resident's bladder during cares. The licensee lacked a policy directing catheter placement during cares and transfers.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31876	A. BUILDING: _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELYSIAN SENIOR HOMES OF LAKE C	480 WEST GRANT STREET LAKE CITY, MN 55041

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02310	Continued From page 120 Centers for Disease Control and Prevention Infection Control, Summary of Recommendations, Guideline for Prevention of Catheter-Associated Urinary Tract Infections (2009), dated November 5, 2015, included, "Keep the collecting bag below the level of the bladder at all times." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul
651-201-4500

Type: Full
Date: *11/30/21*
Time: 10:24:27
Report: 7962211109

Food and Beverage Establishment Inspection Report

Location:
Elysian Senior Homes Of Lake C
480 West Grant Street
Lake City, MN55041
Goodhue County, 25

Establishment Info:
ID #: 0037989
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514488333
ID #:

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

The following orders were issued during this inspection.

3-300A Protection from Contamination: limit hand contact, tasting

3-301.11A ** Priority 1 **

MN Rule 4626.0225A Discontinue bare hand contact with ready-to-eat foods. Use deli tissue, spatulas, tongs, single-use gloves or other dispensing equipment.

CHEF 1 USING BARE HANDS TO DICE TOMATOES, CHEF 1 PUT ON GLOVES, DISCARDED TOMATOES DICED WITH BARE HANDS, DISCUSSED: ALTERNATIVES, HOW TO KEEP GLOVES FROM BEING A SOURCE OF CONTAMINATION

Comply By: 11/29/21

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

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

3 LBS BUTTER ON COUNTER 65 DF, PATS OF BUTTER ON DINING ROOM TABLES, DISCUSSED: TIME AS A PUBLIC HEALTH CONTROL AS AN ALTERNATIVE TO MECHANICAL REFRIGERATION FOR BUTTER FACT SHEET AND FORM SENT WITH REPORT

Comply By: 11/29/21

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

3-302.15A

MN Rule 4626.0255A Thoroughly wash all raw fruits and vegetables before, cutting, combining with other ingredients, cooking, serving, or offering for human consumption in ready-to-eat form. They must be washed in potable water or by using approved chemicals specifIed in part 4626.1625.

CHEF 1 REMOVED WHOLE TOMATOES FROM SHIPPING BOX, WASHED IN PREP SINK, RETURNED WASHED TOMATO TO SHIPPING BOX, DISCUSSED: AFTER THOROUGHLY WASHING PUT PRODUCE IN A CLEAN AND SANITIZED CONTAINER

Comply By: 11/29/21

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

3-304.14B

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

WIPING CLOTH BUCKET 50 PPM QUATERNARY AMMONIA, PER CHEF 1 FILLED AT 6AM , MANUFACTURERS LABEL STATES 150-400 PPM REQUIRED, CFPM FILLED BUCKET FROM SANITIZER DISPENSER 400 PPM, DISCUSSED CHANGING SANITIZER MORE FREQUENTLY

Comply By: 11/29/21

4-500 Equipment Maintenance and Operation

4-501.19CMN

MN Rule 4626.0780C Discontinue the use of a food preparation sink for anything other than food preparation.

SOAP DISPENSER AND HAND WASHING SIGN AT PREP SINK TO LEFT OF COFFEE MACHINE, CFPM REMOVED HAND WASHING SIGN

Comply By: 11/29/21

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 ON PLASTIC BAFFLE AND INTERIOR OF ICE MACHINE BIN, PICTURE TAKEN

Comply By: 11/29/21

4-900 Protecting Clean Items

4-904.13

MN Rule 4626.0975 Protect preset tableware from contamination by wrapping, covering or inverting. Remove exposed preset tableware that is unused when a customer is seated or clean and sanitize exposed preset tableware that is not removed when a customer is seated.

PRESET TABLEWARE ON DINING ROOM TABLES, DISCUSSED WITH CFPM

Comply By: 11/29/21

6-300 Physical Facility Numbers and Capacities

6-301.14

MN Rule 4626.1455 Remove the supply of individual disposable towels and hand soap from food preparation sinks, utensil washing sinks, and mop sinks.

HAND SOAP AT PREP SINK TO LEFT OF COFFEE MACHINE, CFPM STATED WILL BE REMOVED

Comply By: 11/29/21

Surface and Equipment Sanitizers

Hot Water: = at 188 Degrees Fahrenheit
Location: RINSE THERMOMETER ON OUTSIDE OF MACHINE
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: MAX/MIN THERMOMETER SENT THROUGH MACHINE
Violation Issued: No

DISCUSSED HOT WATER SANITIZING REQUIREMENTS WITH CHEF 1 AND CFPM

Quaternary Ammonia: = 50 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: Yes

Quaternary Ammonia: = 150-400 at Degrees Fahrenheit
Location: MANUFACTURERS LABEL STATES 150-400 PPM REQUIRED
Violation Issued: No

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: CFPM EMPTIED AND FILLED BUCKET FROM SANITIZER DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Walk-In Freezer
Temperature: -4 Degrees Fahrenheit - Location: THERMOMETER ON OUTSIDE OF MACHINE
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 34 Degrees Fahrenheit - Location: THERMOMETER ON OUTSIDE OF MACHINE
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 37 Degrees Fahrenheit - Location: POTATO SALAD DATED 11/30
Violation Issued: No

Process/Item: On Counter
Temperature: 65 Degrees Fahrenheit - Location: 3 LBS OF BUTTER ON COUNTER 65 DF, PATS OF BUTTER ON DINING ROOM TABLES, DISCUSSED HAVING A WORKING AMOUNT OUT OF REFRIGERATION BY USING TIME AS A PUBLIC HEALTH CONTROL AS AN ALTERNATIVE TO MECHANICAL REFRIGERATION FACT SHEET AND FORM SENT WITH REPORT
Violation Issued: Yes

Process/Item: Thermometer
Temperature: 34 Degrees Fahrenheit - Location: FACILITY THERMOMETER IN ICE WATER - CALIBRATION CHECK
Violation Issued: No

Process/Item: Thermometer
Temperature: 32 Degrees Fahrenheit - Location: CALIBRATED FACILITY THERMOMETER IN ICE WATER - CALIBRATION CHECK
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: SINGLE DOOR COOLER #1 CUCUMMBER IN PLATED SALAD DATED 11/29
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: SINGLE DOOR COOLER #1 INTERIOR HANGING THERMOMETER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 34 Degrees Fahrenheit - Location: SINGLE DOOR COOLER #1 EXTERIOR THERMOMETER
Violation Issued: No

Process/Item: Cooking
Temperature: 178 Degrees Fahrenheit - Location: BROTH SOUP SIMMERING ON RANGE
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 38 Degrees Fahrenheit - Location: BOTTOM OF PREP COOLER SLICED TURKEY NO STORAGE IN TOP OF PREP COOLER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: SINGLE DOOR COOLER #2 INTERIOR HANGING THERMOMETER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: SINGLE DOOR COOLER #2 EXTERIOR THERMOMETER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 44 Degrees Fahrenheit - Location: SINGLE DOOR COOLER #2 CHOPPED TOMATOS DATED 11/27, CFPM STATED THEY WERE USED TO MAKE PLATED SALADS THIS MORNING (APPROXIMATELY 6), DISCUSSED RETURNING PRODUCT IMMEDIATELY TO REFRIGERATION WHEN DONE, USE TOP TOP SHELF WHERE COLD AIR COMES INTO UNIT
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 42.3 Degrees Fahrenheit - Location: SINGLE DOOR COOLER #2 TURKEY SANDWICH, NO DATE, 42.3 DF CFPM DISCARDED, DISCUSSED IF SANDWICH WAS MADE WITHIN 24 HOURS IT DID NOT NEED TO BE DISCARDED
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: SINGLE DOOR COOLER #2 EXTERIOR THERMOMETER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: SINGLE DOOR COOLER #2 GARLIC AND OIL ON TOP SHELF
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	0	6

Establishment Info:

11-29-21
COMMENTS CONTINUED FROM REPORT:

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

(3 LBS OF BUTTER ON COUNTER 65 DF, PATS OF BUTTER ON DINING ROOM TABLES)... DISCUSSED WITH CFPM HAVING A WORKING AMOUNT OUT OF REFRIGERATION BY USING TIME AS A PUBLIC HEALTH CONTROL AS AN ALTERNATIVE TO MECHANICAL REFRIGERATION FACT SHEET AND FORM SENT WITH REPORT

CHOPPED TOMATO DATED 11/27, CFPM STATED THEY WERE USED TO MAKE PLATED SALADS THIS MORNING (APPROXIMATELY 6), DISCUSSED RETURNING PRODUCT IMMEDIATELY TO REFRIGERATION WHEN DONE, USE TOP TOP SHELF WHERE COLD AIR COMES INTO UNIT

TURKEY SANDWICH, NO DATE, 42.3 DF CFPM DISCARDED, DISCUSSED IF SANDWICH WAS MADE WITHIN 24 HOURS IT DID NOT NEED TO BE DISCARDED

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7962211109 of 11/30/21.

Certified Food Protection Manager: Sara Paul

Certification Number: FM101594 Expires: 07/09/22

Inspection report reviewed with person in charge and emailed.

Signed: _____

Sara Paul
Senior Housing Manager

Signed: 7962

Heather Flueger
Public Health Sanitarian
Rochester District Office
507-208-3096
heather.flueger@state.mn.us

Report #: 7962211109

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul

No. of RF/PHI Categories Out	4	**Date**	11/30/21
No. of Repeat RF/PHI Categories Out	0	**Time In**	10:24:27
Legal Authority MN Rules Chapter 4626		**Time Out**	

Elysian Senior Homes Of Lake C	**Address** 480 West Grant Street	**City/State** Lake City, MN	**Zip Code** 55041	**Telephone** 6514488333
License/Permit # 0037989	**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
Supervision			
1	IN OUT		
PIC knowledgeable; duties & oversight			
2	IN OUT N/A		
Certified food protection manager, duties			
Employee Health			
3	IN OUT		
Mgmt/Staff;knowledge,responsibilities&reporting			
4	IN OUT		
Proper use of reporting, restriction & exclusion			
5	IN OUT		
Procedures for responding to vomiting & diarrheal events			
Good 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	X	Wiping cloths: properly used & stored		
42	X	Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44	X	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		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 12/01/21

Inspector (Signature) 7962