Electronically Delivered

August 19, 2024

Licensee
Nature's Point Assisted Living
1717 University Drive Southeast
Saint Cloud, MN 56304

RE: Project Number(s) SL21937015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 24, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted no 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21937	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATURE'S POINT ASSISTED LIVING	1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21937015 On July 22, 2024, through, July 24, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 32 residents receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been 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 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 evaluators ' 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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

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0 470	Continued From page 2 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 held an assisted living license. The facility was licensed for a capacity of 39 and had a current census of 32 residents. During the entrance conference on July 22, 2024, at 10:30 a.m., clinical nurse supervisor (CNS)-C and licensed assisted living director (LALD)-A stated the usual staffing schedule for the facility was as follows: -CNS-C stated she "really does not have hours," but she was on site from 8:00 a.m. to 6:00 p.m., Monday through Friday -the day shift was staffed with two unlicensed personnel (ULP) from 6:00 a.m. to 2:30 p.m. and a "bath aide" from 9:00 a.m. to 3:00 p.m., Monday through Friday -the afternoon shift was staffed with two ULPs from 2:00 p.m. to 10:00 p.m. -the night shift was staffed with one ULP from 10:00 p.m. to 6:30 a.m. On July 22, 2024, at 10:57 a.m., during a tour of the facility with CNS-C the surveyor observed the staffing plan/schedule posted on a wall in a room marked "employees only" on the door. CNS-C stated residents could go into the room as it was not locked, but added residents were not supposed to go into the room. CNS-C confirmed the staffing plan/schedule was not posted in a central location and available to residents and visitors.	0 470		

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0 470	Continued From page 3 On July 23, 2024, at 8:42 a.m., the surveyor was given a "staffing plan" dated December 2023, authenticated by LALD-A and CNS-C, which noted: Reason for changes: -a bath aide was added due to the high number of morning baths scheduled from Monday to Friday, as well as an increase in the census -this change results in an additional six hours daily for the bath aide position -two additional staff members were hired to accommodate the increased hours. On July 23, 2024, at 8:37 a.m., LALD-A stated he wanted to be honest. LALD-A stated he just typed up what was in an email. LALD-A adding he and CNS-C just signed the paper. LALD-A said he could not say that "it" (staffing plan) was done twice yearly but added he understood the importance. LALD-A said moving forward the staffing plan would be evaluated twice a year. The licensee's Staffing policy dated May 20, 2023, noted the clinical nurse supervisor would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the resident's needs 24-hours a day, seven-days a week. The clinical nurse supervisor must ensure that staffing levels were adequate to address the following: a. each resident's needs, as identified in the resident's service plan and assisted living contract b. each resident's acuity level, as determined by the most recent assessment or individualized review c. the ability of staff to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of	0 470		

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0 470	Continued From page 4 the facility premises d. whether the facility had a secured dementia care unit, and e. staff experience, training, and competency. The daily work schedule must be posted, at the beginning of each work shift in a central location in each building of a facility, or campus, accessible to staff, residents, volunteers, and the public. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4, effective October 2022, the daily work schedule in item A must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective October 2022, the CNS must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 5 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 22, 2023. for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to	0 580		

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0 580	Continued From page 6 be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. 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 the residents). The findings include: During the entrance conference on July 22, 2024, at approximately 10:45 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C stated quality management meetings were held. On July 22, 2024, at 1:25 p.m., LALD-A and CNS-C stated they went over incidents, tracking, etcetera, but added they (licensee) had nothing in writing for this building, adding only the skilled nursing facility had meeting notes. LALD-A and CNS-C confirmed there was not a quality management program in place as required.	0 580		

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0 580	Continued From page 7 The licensee's QAPI (Quality Assurance and Performance Improvement) policy dated July 10, 2020, noted meetings would be held at least quarterly and with frequency to conduct required QAPI activities QAPI plan would be reviewed annually and with any significant change at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content in common areas to include posting the 911 emergency number in common areas and near telephones provided by the assisted living. This had the potential to affect all 32 residents, staff, and visitors.	0 640		

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0 640	Continued From page 8 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 July 22, 2024, at approximately 10:45 a.m., during the facility tour with licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C, the surveyor did not observe 911 posted on or near telephone or in the commons area as required. On July 22, 2024, at 10:55 a.m., CNS-C stated 911 "was" posted by a phone available for resident use. CNS-C added one of the residents must have removed the call 911 sign as there was no 911 sign posted near the telephone for resident use. LALD-A stated 911 was posted in the front of the building. On July 22, 2024, at 1:53 p.m., LALD-A stated he was incorrect. The only place 911 was posted was inside of the yellow emergency binder. LALD-A confirmed the 911 emergency number was not posted at or near telephones or in the commons area as required. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy dated May 30, 2023, noted the facility would post 911 emergency number in common areas and near telephones provided by the assisted living facility.	0 640		

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0 640	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content for one of one employee (unlicensed personnel (ULP)-B).	0 650		

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0 650	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B was hired on March 13, 2024, to provide direct care services to the licensee's residents. On July 22, 2024, at 11:20 a.m., the surveyor observed ULP-B at the west medication cart preparing R7 medication for unplanned time away. CNS-C was in the vicinity and asked R7 if she would like the sheet of paper (directions for medications). R7 declined the paper stating "no, no" I know what I take (medications). ULP-B's employee record dated April 12, 2024, included training and competency for oral medications. ULP-B's employee record did not include training and competency for unplanned time away medication. On July 24, 2024, at 9:17 a.m., clinical nurse supervisor (CNS)-C stated she completed unplanned times away medication training and competencies with ULPs when doing medication training but stated there was no evidence in the ULP records of this training or competency as required. The licensee's Employee Records policy dated May 30, 2023, noted employee records for each person would include records of all training and in-service education required and/or provided	0 650		

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0 650	Continued From page 11 including record of competency testing as required. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATURE'S POINT ASSISTED LIVING	1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304

(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
0 660	Continued From page 12 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) for two of two employees (clinical nurse supervisor (CNS)-C, unlicensed personnel ULP-D). 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:	0 660		

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0 660	Continued From page 13 The facility's TB risk assessment was completed on September 20, 2023, and was determined to be a low risk level. CNS-C CNS-C was hired on March 20, 2023, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On July 22, 2024, at 11:20 a.m., the surveyor observed CNS-C ask R7 if she would like the sheet of paper (directions for medications) as ULP-B was preparing R7's medications for unplanned time away. R7 declined the paper stating "no, no" I know what I take (medications). CNS-C's employee record included: -Baseline TB Screening Tool for Health Care Workers (HCWs) dated March 20, 2024 (sic) -QuantiFERON-TB Gold test result dated August 15, 2022, (218 days from hire due on or after June 18, 2023, until March 20, 2023). CNS-C's employee record did not include an IGRA (serum blood test) or TST (first step) dated within 90 days of hire. ULP-D ULP-D was hired on June 3, 2024, to provide direct care and services to the licensee's residents. On July 23, 2024, at 7:15 a.m., the surveyor observed ULP-D administer R5's morning medication. ULP-D's employee record included: -Baseline TB Screening Tool for HCW dated June 3, 2024	0 660		

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0 660	Continued From page 14 -QuantiFERON-TB Gold test result dated January 29, 2024, (127 days from hire, due on or after March 5, 2024, until June 3, 2024). ULP-D's employee record did not include an IGRA (serum blood test) or TST (first step) dated within 90 days of hire. On July 24, 2024, at 10:37 a.m., registered nurse (RN)-K stated prior TB testing was good for 90 days prior to hire. CNS-C stated she was not aware of the 90-day rule, adding she thought the TB blood test was good for one year. RN-K and CNS-C confirmed TB testing completed did not meet requirements. The licensee's Tuberculosis Surveillance and Control policy dated June 14, 2024, noted guidelines for screening is applicable to all residents new to the facility, employees of the facility, consultants or temporary agency, respite resident, adult day service participants, and volunteers if applicable. All resident new to assisted living facility who do not have documentation of a previous skin test reaction great than 10 mm (measurement) or a history of adequate treatment of TB infection or disease, previous documented negative interferon gamma release assay (IGRA) blood test within past 90 days, or TB skin test (TST) within past 90 days shall have the initial test of a Mantoux PPD two-step skin TST to rule out TB within 72 hours of admission. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, screen (no symptoms of active TB disease) and a negative IGRA or TST (first step) dated within 90 days before hire.	0 660		

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0 660	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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	0 680		

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0 680	Continued From page 16 emergency preparedness plan (EPP) posted in a prominent area and developed with all the required content. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 22, 2024, at approximately 11:00 a.m., during a tour of the facility, the surveyor observed a yellow emergency binder in the entry of the facility. The binder contained EPP policies. The yellow emergency binder was reviewed by the surveyor, the binder contained: -policy & procedure active shooter -policy & procedure adverse event communication -policy & procedure apartment evacuation -policy & procedure bioterrorism treats -policy & procedure bomb threat -policy & procedure chemical spills -policy & procedure climate control failure during hot temperatures -policy & procedure elevator -policy & procedure emergency evacuation -policy & procedure fire -policy & procedure hot weather and extreme high temperature precautions -policy & procedure medical emergency response -policy & procedure severe cold weather conditions	0 680		

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0 680	Continued From page 17 -policy & procedure severe weather -policy & procedure sun exposure precautions -policy & procedure winter storm safety precautions. On July 22, 2024, at 11:38 a.m., licensed assisted living director (LALD)-A confirmed the yellow binder only contained the policies for EPP. LALD-A said the EPP was upstairs in the skilled nursing facility. LALD-A confirmed the EPP was not in a central area as required. On July 22, 2024, at 12:50 p.m., LALD-A reviewed a red EPP binder with the surveyor. LALD-A and registered nurse (RN)-K confirmed the EPP did not identify the population at risk as required. The licensee's Emergency Preparedness policy dated May 13, 2023, noted the facility had in place an effective and compliant Emergency Preparedness Plan. The plan would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z. The facility emergency preparedness plan would include all required elements of appendix Z. The plan would be in writing and reviewed annually. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by	0 680		

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0 680	Continued From page 18 reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (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	0 810		

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0 810	Continued From page 19 the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 24, 2024, at 2:30 p.m., licensed assisted living director (LALD)-A and director of maintenance (DM)-J provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee's FSEP failed to include the following: The FSEP combined procedures with the long-term care facility that was connected to this facility but failed to include site specific actions for staff and residents to take on the assisted living portion. On July 24, 2024, at 2:30 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing	0 810		

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0 810	Continued From page 20 them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated with the assisted living license for two of three employees (unlicensed personnel (ULP)-B, ULP-D). 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	01290		

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01290	Continued From page 21 of the residents). The findings include: ULP-B ULP-B was hired on March 13, 2024, to provide direct care services to the licensee's residents. On July 22, 2024, at 11:20 a.m., the surveyor observed ULP-B at the west medication cart preparing R7 medication for unplanned time away. ULP-B's record lacked documentation of a background study affiliated with the facility's license. ULP-B's record included a background study for another license, 614, which was under the same ownership. ULP-D ULP-D was hired on June 3, 2024, to provide direct care services to the licensee's residents. On July 23, 2024, at 7:03 a.m., the surveyor observed ULP-D apply compression stockings (TEDs) to R9's lower legs. ULP-D's record lacked documentation of a background study affiliated with the facility's license. ULP-B's record included a background study for another license, 614, which was under the same ownership. On July 22, 2024, at 2:32 p.m., licensed assisted living director (LALD)-A stated "we" (licensee) are the only campus that has shared staff, and he (they/licensee) were not aware of the requirement to have each staff affiliated with each health facility identification (HFID) number. LALD-A stated seven staff were shared.	01290		

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01290	Continued From page 22 The licensee's Background Study policy dated May 30, 2023, noted the facility would conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors. No employee may provide direct services and have independent direct contact with any resident until acceptable result of the background study had been received. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01420		

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01420	Continued From page 23 review, the licensee failed to provide complete written instructions in the resident record for delegated tasks for one of two residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's diagnoses include diabetes, and hypertension (HTN/high blood pressure), shortness of breath, Alzheimer's disease, morbid obesity, and malaise. R5's record included Focus/Goal/Interventions/Tasks form revised on January 8, 2024, included: -daily weight due to pedal edema (ankles and/or feet are swollen due to accumulation of fluid). R5's assessment dated July 8, 2024, included: -nutrition: unplanned significant weight gain, blank -venous: edema, no. R5's Weights and Vitals Summary included: -June 24, 2024, 209 pounds (lbs) -June 25, 2024, 209 lbs -July 9, 2024, 210 lbs -July 15, 210.6 lbs -July 17, 2024, 210.5 lbs. On July 23, 2024, at 11:33 a.m., the surveyor observed unlicensed personnel (ULP)-D check	01420		

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01420	Continued From page 24 R5's blood sugar using correct technique. On July 23, 2024, at 2:23 p.m., clinical nurse supervisor (CNS)-C stated, "that was on me" (directions not in the record for R5's weight). CNS-C said she requested staff monitor R5's weight and confirmed R5's record did not include specific instructions for ULPs as required. The licensee's Delegation of Nursing Tasks policy dated October 24, 2022, noted prior to delegating a nursing task a registered nurse (RN) developed specific written instructions for each resident and documented those instructions in the resident's medication record/MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all	01640		

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01640	Continued From page 25 services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans were revised to include provided services for one of one resident (R9). 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: R9's diagnoses include hemiplegia and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke/when blood supply to part of the brain is blocked or reduced) affecting left non-dominant side, diabetes, and heart disease. R9's service plan dated July 29, 2023, indicated R9 had potential impairment to skin integrity of left arm related to left sided weakness and required one person assist with dressing, and to assist with compression garment.	01640		

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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
01640	Continued From page 26 R9's medication administration record (MAR) dated July 1, 2024, through July 22, 2024, included: -assist (name) R9 with applying his right hand spilt (blue in color) at bedtime one time a day -assist (name) R9 with removal of hand splint upon rising one time a day. On July 23, 2024, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-D apply compression stockings (TEDs) to R9's lower legs. On R9's kitchen table was blue sling/brace. ULP-D said she had assisted R9 with brace but added most of the time the night shift assisted R9 with brace. On July 24, 2024, at 2:09 p.m., clinical nurse supervisor (CNS)-C stated R9's service plan did not include brace application. CNS-C said she was not aware service plans needed to be printed and signed when services were added or when service plans were revised. CNS-C confirmed service plans were not revised as required. The licensee's Resident Service Plan policy dated May 14, 2021, noted the service plan would be updated to reflect current resident needs, preferences, and interventions. The service plan would be individualized and kept current at all times. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21937	A. BUILDING: _____ B. WING _____	07/24/2024

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01650	Continued From page 27 (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 one of one resident (R9). 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	01650		

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01650	Continued From page 28 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: R9's diagnoses include hemiplegia and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke/when blood supply to part of the brain is blocked or reduced) affecting left non-dominant side, diabetes, and heart disease. R9's service plan dated July 29, 2023, indicated R9 received medication administration, glucose (sugar) monitoring, grooming assist, toilet assist, assist with compression garment, dressing assist, bathing assist, laundry and housekeeping services and registered nurse (RN) evaluation as needed. On July 23, 2024, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-D apply compression stockings (TEDs) to R9's lower legs. R9's Service Plan did not include the following required content: - the schedule and methods of monitoring assessments of the resident - the schedule and methods of monitoring staff providing services; and A contingency plan that included: - the actions to be taken if the scheduled service cannot be provided - information and a method to contact the facility - 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	01650		

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01650	Continued From page 29 identification of and information as to who has authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not summoned consistent with chapters 145 B and 145C, and declarations made by the resident under those chapters. On July 24, 2024, at 11:11 a.m., R9's service plan was reviewed with clinical nurse supervisor (CNS)-C. CNS-C stated she was not able to find the above noted content. CNS-C added service plans did not include who not to contact either. On July 24, 2024, at 12:43 p.m., CNS-C stated all service plans were the same, same template used. The licensee's Resident Service Plan policy dated May 14, 2021, noted services to be provided are to be clearly identified, with frequency of service. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:	01730		

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01730	Continued From page 30 (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all required content for one of two residents (R5).	01730		

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01730	Continued From page 31 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: R5's diagnoses include diabetes, hypertension (HTN/high blood pressure,) and Alzheimer's disease. R5's record included a Focus/Goal/Interventions/Tasks form revised on January 8, 2024, included: -tenant (resident) is unable to self-administer any medication related to poor dexterity, tenant preference -medication administration by facility, staff will administer with nursing oversight. On July 23, 2024, at 11:33 a.m., the surveyor observed unlicensed personnel (ULP)-D check R5's blood sugar using correct technique to obtain a reading of 445 and administer R5's medication. R5's assessment dated May 17, 2024, included: -notes reviewed for previous 12 months from previous medical providers, hospital notes, and post-acute care facilities, as available: check -a review of medications including prescriptions, over-the counter medications, supplements and treatments has been completed by a RN (registered nurse) -does the resident want to self-manage	01730		

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01730	Continued From page 32 medication? no. R5's record lacked identification of persons responsible for monitoring medication supplies and ensuring medication refills were ordered in a timely basis; and a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. On July 24, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-C stated she was not able to locate a medication assessment in R5's record. CNS-C added there were four file cabinets full of documents when she started working for the licensee and she had been uploading information found. CNS-C said she was getting to "them" (to complete medication assessments) as able, and she was aware of the requirement. CNS-C confirmed R5's record lacked the required documentation. The licensee' Medication and Treatment Administration policy dated May 30, 2023, noted a RN (registered nurse) must conduct a face-to-face resident assessment to determine what medication management or treatment/therapy service would be provided and how those services would be provided. The licensee's Medication Self Administration policy dated March 1, 2024, noted, resident shall have a screen completed by a licensed nurse to determine factors that may impact the safe administration of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses include chronic obstructive pulmonary disease (COPD/chronic inflammatory lung disease that causes obstructed airflow from the lungs).	01750		

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01750	Continued From page 34 R2's Focus, Goal, Interventions/Tasks dated October 12, 2023, included: -resident requires basic AL (assisted living) service including providing verbal or visual reminders to take regularly scheduled medications which included bring set up medications, medication in their original containers with liquid or food for medication administration, preparing specialized services provided by RN medication management services, delegated tasks assigned by an RN within scope of practice - the resident is unable to self-administer medications, medications will be administered at the preferred time(s) after the Price is Right and before bed, approximately 2200 (10:00 p.m.) On July 23, 2024, at 9:39 a.m., the surveyor observed unlicensed personnel (ULP)-D hand R2 an Anoro Ellipta inhaler (COPD). R2 placed the inhaler up to her lips. R2 blew out and then inhaled the medication. ULP-D stated, "there you go." ULP-D said, you (R2) want to drink some water and spit it out. ULP-D handed R2 a cup of water and a small cup to spit the water into. ULP-D stated R2's record did not have directions/instructions, but she was a TMA (trained medication assistance) and she (ULP-D) knew about inhalers. R2's medication administration record (MAR) dated July 1, 2024, through July 24, 2024, included: -Anoro Ellipta inhalation aerosol powder breath activated 62-5-25 MCG/ACT (micrograms/asthma control test, a brief self-administered questionnaire determine asthma control), one inhalation inhale orally one time a day for obstructive airway disease.	01750		

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	21937	A. BUILDING: _____ B. WING _____	07/24/2024

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01750	Continued From page 35 R2's prescriber's order dated February 7, 2024, included the above medication. On July 24, 2024, at 10:13 a.m., clinical nurse supervisor (CNS)-C stated ULP-D told her "yesterday" that R2's record lacked instructions for inhaler. The manufacturer's instructions were reviewed with CNS-C and CNS-C stated R2's record did not include specific instruction in R2's record as required. CNS-C confirmed ULP-D should have instructed R2 to hold her breath after the inhaling of medication and that R2's mouth did not require rinsing after medication administration Manufacturer's instructions for Anoro Ellipta dated June 2021, noted slide the mouthpiece down, you should hear a click and the counter will count down by one number. You do not need to shake. Breath out, put the mouthpiece between your lips and close your lips firmly around it, take one long, steady, deep breath in through your mouth, do not breath in through your nose. Remove the inhaler from your mouth and hold your breath for about three to four seconds (or as long as comfortable for you). The licensee' Medication and Treatment Administration policy dated May 30, 2023, noted a RN (registered nurse) must specify, in writing, specific instructions for each resident and document those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

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01760	Continued From page 36	01760		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication was administered according to the medication administration plan for one of three residents (R10). In addition, the licensee failed to ensure the steps of the medication administration process was followed for one of two unlicensed personnel (ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01760		

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01760	Continued From page 37 The findings include: R10's diagnoses include diabetes, cardiovascular (heart) disease, and chronic obstructive pulmonary disease (COPD/chronic inflammatory lung disease that causes obstructed airflow from the lungs). R10's Focus, Goal, Interventions/Tasks form dated January 8, 2024, included: -medication administration by facility. Staff will administer with nursing oversight -resident is unable to self-administer any prescribed medications related to failure to successfully manage medication effectively. R10's prescriber's orders dated February 8, 2024, included: -Refresh ophthalmic solution 1.4-0.6% (polyvinyl alcohol-povidone) instill one drop in both eyes three times a day for dry eyes -Alaway ophthalmic solution 0.025 % (ketotlen furnarate/allergens) instill 1 drop in both eyes two times a day for dry eyes -Duoneb solution 0.5-2.5 (3) milligrams (mg), milliliter (ml), one vial inhale orally four times a day related to COPD. May not mix one neb (nebulizer/ small machine that creates a mist out of liquid medication, allowing for quicker and easier absorption of medication into the lungs) solution together give nebs one solution at a time -budesonide suspension 1 mg/2 ml one dose inhale orally two times a day related to COPD, may not mix neb solutions- administer one, then administer second solution. R10's medication administration record (MAR) dated June 1, 2024, through June 30, 2024, included: -budesonide suspension 1 mg/2 ml one dose	01760		

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01760	Continued From page 38 inhale orally two times a day. may not mix neb solutions, doing one, then administer second solution -name (R10) is NOT OKAY to self administer his neb treatments. Please either sit with him, or have his door open during administration and stay within close proximity. Do not mix his neb treatments, and rinse his mask between solutions, two times a day -do not leave medication for nebulizer in room for resident to self administer, we must put medication in neb rinse neb supplies and let air dry after each use, every shift -Alaway ophthalmic solution 0.025% instill one drop in both eyes two times a day for dry eyes (7:00 a.m.) -Refresh ophthalmic solution, instill one drop in both eyes three times a day for dry eyes (8:00 a.m.) MEDICATION ADMINISTRATION PLAN On July 23, 2024, at 6:40 a.m., the surveyor observed ULP-B prepare R10's morning medication. ULP-B and took a medication cup which contained oral medication, a bottle of Alaway eye solution, and a vial of a budesonide nebulizer medication to R10's room. ULP-B administered R10's oral medication. ULP-B handed the bottle of eye Alaway solution to R10 and R10 instilled the eye solution into both eyes. ULP-B put the content of the nebulizer vial into the nebulizer cup and left R10's room with the door open. On July 23, 2024, at 10:01 a.m., clinical nurse supervisor (CNS)-C said ULP-B should have administered R10's eye solution medication. In addition, CNS-C stated ULP-B should have ensured R10 completed the nebulizer treatment. CNS-C added R10 will put the nebulizer down	01760		

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01760	Continued From page 39 and not complete the treatment and so ULPs need to monitor R10's nebulizer treatment. CNS-C confirmed R10's medication was not administered per R10's medication plan. DOCUMENTATION OF MEDICATION ADMINISTRATION On July 23, 2024, at 6:50 a.m., the surveyor observed ULP-B standing at the medication cart outside of R10's room and down the hallway. R10's door was open. The surveyor heard R10's nebulizer machine turn on. ULP-B commented, R10 turned the nebulizer machine on, he (ULP-B) could now document R10's nebulizer as administered. On July 24, 2024, at 10:57 a.m., CNS-C and registered nurse (RN)-K stated documentation of medication administration should be completed after the medication was administered, adding ULP-B should have waited to document R10's nebulizer and ensured R10 completed the treatment. The licensee' Medication and Treatment Administration policy dated May 30, 2023, noted a RN must instruct the ULP on the following medication administration tasks before delegating the task to them: -instruct the ULP in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP had demonstrated the ability to competently follow the procedures -documentation after assistance with medication administration, of the date, time, dosage, and method of administration of all medications -communicate with the ULP about the individual needs of the resident.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21937	A. BUILDING: _____ B. WING _____	07/24/2024

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NATURE'S POINT ASSISTED LIVING	1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304

(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
01760	Continued From page 40 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations for two of two medication refrigerators (east, west). In addition, the licensee failed to ensure medication was secured in a locked area for R9. 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: MEDICATION STORED ACCORDING TO MANUFACTURER'S RECOMMENDATIONS On July 22, 2024, at 11:12 a.m., the surveyor	01880		

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01880	Continued From page 41 toured the facility with licensed assisted living director (LALD)-A, and clinical nurse supervisor (CNS)-C including a review of the medication refrigerators. EAST REFRIGERATOR LALD-A stated the current temperature was 30 degrees Fahrenheit (F). CNS-C stated the temperature should be 36-46 degrees F, adding "that is too cold" (current temperature of refrigerator). LALD-A adjusted the temperature of the east medication refrigerator. CNS-C confirmed the following: -12 unopened Novolog (short-acting) 100 units/milliliter (ml) insulin pens for R3 -one unopened latanoprost 0.0005% (eye pressure) solution for R4. East refrigerator temperature log dated July 1, 2024, through July 22, 2024, noted: -keep refrigerated medications between 36 degrees and 46 degrees at all times. If the fridge temperature is lower than 36, or higher then 46, notify the RN (registered nurse) immediately. The refrigerator temperature had been monitored 0 out of 22 opportunities. WEST REFRIGERATOR On July 22, 2024, at 12:50 p.m., the west medication refrigerator temperature was reviewed with CNS-C and the current temperature was 40 degrees F. On July 23, 2024, at 7:10 a.m., CNS-C confirmed the following: -three unopened Novolog 100 units/ml pens for R6 -one unused Ozempic (diabetes/weight loss) three ml pen for R6 -one unused Spikevax (COVID-19) for R7	01880		

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01880	Continued From page 42 -four unused Mounjaro (diabetes) 0.5 ml pens for R8. West refrigerator temperature log dated July 1, 2024, through July 20, 2024, noted: -keep refrigerated medications between 36 degrees and 46 degrees at all times. If the fridge temperature is lower than 36, or higher then 46, notify the RN (registered nurse) immediately. The refrigerator temperature had been monitored 0 out of 20 opportunities. On July 22, 2024, at 1:47 p.m., the east and west refrigerator temperature logs were reviewed with CNS-C. CNS-C stated refrigerator temperatures were to be checked by unlicensed personnel (ULP) when narcotic count was being completed and confirmed neither refrigerator's temperature was being monitored as required. The manufacturer's instructions for Humalog insulin dated December 5, 2022, noted unopened Humalog should be stored in a refrigerator 36-46 degrees F but do not allow to freeze. The manufacturer's instructions for latanoprost dated February 1, 2024, noted store unopened bottles in the refrigerator. The manufacturer's instructions for Ozempic dated July 7, 2022, noted should stay refrigerated until the first time you use it. You should keep it in the refrigerator between 36 F to 46 F when it's new and unused. The manufacturer's instructions Mounjaro dated November 3, 2023, noted store in refrigerator at 36 F to 46 F. The manufacturer's instructions Spikevac dated	01880		

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01880	Continued From page 43 October 27, 2023, noted vials may be stored in refrigerated between 36 F to 46 F for up to 30 days before first use. The manufacturer's instructions for Lantus insulin dated August 2022, indicated unopened Lantus should be stored in a refrigerator 36-46 degrees F. Do not allow Lantus to freeze. Do not put Lantus in a freezer or next to a freezer pack. The licensee's Mediation Storage policy dated February 12, 2024, noted medications requiring refrigeration should be stored in the refrigerator. Please refer to package insert for specific temperature requirements for medication. SECURE MEDICATION STORAGE R9's diagnoses include diabetes, dementia, psychotic disturbance, mood disturbance, major depressive disorder, and anxiety. R9's service plan dated July 29, 2023, indicated R9 received medication administration two times daily, and R9 did not wish to self-administer medication. R9's assessment dated August 10, 2023, noted R9 was unable to self-administer most medication related to forgetfulness, R9 would receive medications safely and as prescribed. Medications would be administered by licensed or certified team member. On July 23, 2024, at 7:03 a.m., the surveyor observed ULP-D apply compression stockings (TEDs/ compression hose) to R9's lower legs. On R9's kitchen table was an opened container of melatonin five milligrams (mg) (sleep), and an open bottle of anti-acid. On a side table near a recliner in R9's room was an opened container of	01880		

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01880	Continued From page 44 melatonin five mg, and an opened container of "all day pain relief." On July 23, 2024, at 10:03 a.m., CNS-C stated R9 should not have medications in his room per his medication assessment. CNS-C added R9 liked to keep quarters in the melatonin containers. CNS-C observed one of the two melatonin containers had quarters in it and one melatonin contained medication. CNS-C explained to R9 he received melatonin each evening per provider's order, and he (R9) should not be taking additional melatonin. CNS-C stated R9 did not have an order for anti- acid medication and R9 had a PRN (as needed or desired) order for pain relief. CNS-C confirmed R9's medications were not to be self-administrated and all R9's medication were to be secured. The licensee's Mediation Storage policy dated February 12, 2024, noted medications are stored in a safe, secure storage with safe handling. Medications requiring refrigeration should be stored in the refrigerator, refer to package insert for specific temperature requirements of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the	01890		

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01890	Continued From page 45 expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of three residents (R2, R5) in one of two medication carts (east). 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: On July 22, 2024, at approximately 11:00 a.m., the surveyor and clinical nurse supervisor (CNS)-C reviewed the contents of the locked east medication cart. CNS-C observed and confirmed the following: -one opened Lantus (long-acting) 100 units/milliliter (ml) insulin pen for R5. The Lantus pen did not indicate when the pen was opened or when it would expire -one opened Anoro Ellipta 62.5 inhaler for R2. The Anoroa inhaler noted it was filled on January 13, 2024. On July 22, 2024, at approximately 1:00 p.m.,	01890		

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01890	Continued From page 46 manufacturer's instructions for R2's Anoro inhaler were reviewed with CNS-C. CNS-C confirmed R2's Anoro inhaler should have been dated, open date and date of expiration. CNS-C stated was aware of the need to date insulin. The manufacturer's instructions for Lantus pens dated 2022, noted after 28 days throw your opened Lantus pen away, even if it still had insulin in it. The manufacturer's instructions for Anoro Ellipta dated February 8, 2024, noted throw the inhaler away six weeks after opening, or when the dose indicator shows a zero (whichever comes first). The licensee's Medication Self Administration policy dated March 1, 2024, noted, no discontinued, outdated, or deteriorated medication should be available for use in the facility. All such medications are destroyed per policy. Multi-dose vials must be dated upon opening and discharged within 30 days unless otherwise specified by manufacturer. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the	01950		

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01950	Continued From page 47 appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for two of two residents (R9, R5) receiving treatments. 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: R9 R9's diagnoses include hemiplegia and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke/when blood supply to part of the brain is blocked or reduced) affecting left non-dominant side, diabetes, and	01950		

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01950	Continued From page 48 heart disease. R9's service plan dated July 29, 2023, indicated R9 had potential impairment to skin integrity of left arm related to left sided weakness. R9 required one person assist with dressing, and to assist with compression garment. On July 23, 2024, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-D apply compression stockings (TEDs) to R9's lower legs. On R9's kitchen table was blue sling/brace. R9's medication administration record (MAR) dated July 1, 2024, through July 22, 2024, included: -assist to apply compression socks in the morning, one time a day -remove compression socks from bilateral lower extremities Wash with warm soapy water, rinse, and hang dry one time a day -assist (name) R9 with removal of hand splint upon rising one time a day -assist (name) R9 with applying his right hand spilt (blue in color) at bedtime one time a day. R9's prescriber order dated September 22, 2023, included: -reviewed splint program established last time in SNF (skilled nursing facility). R9's prescriber order dated June 27, 2024, included: -TED stocking 15-20 mm (millimeters of mercury/measurement) apply every morning and remove every bedtime. Diagnosis lower extremity edema (swelling/ fluid retention). On July 24,2024 at 12:43 p.m., clinical nurse supervisor (CNS)-C stated R9's record did not	01950		

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01950	Continued From page 49 include when to notify nurse of concerns such as redness. CNS-C stated she had the information in R9's record but it did not get "put back in" (added to record) when he returned from a hospital visit. CNS-C confirmed R9's record did not contain specific instructions for R9's treatments. R5 R5's diagnoses include diabetes, and hypertension (HTN/high blood pressure). R5's included a Focus/Goal/Interventions/Tasks form revised on January 8, 2024, included: -blood sugar checks as ordered by MD (medical doctor) -staff will monitor vital signs and/or weight per physician orders. On July 23, 2024, at 11:33 a.m., the surveyor observed ULP-D check R5's blood sugar using correct technique to obtain a reading of 445. ULP-D commented "oh that (blood sugar) is high." ULP-D stated she would update CNS-C of R5's blood sugar reading. R5's MAR dated July 1, 2024, through, July 22, 2024, included: -check blood glucose two times a day every other day -check pulse and blood pressure one time a day. R5's prescriber order dated May 2, 2024, included: -may check blood glucose (sugar) twice daily rotating (sites). R5's prescriber order dated May 24, 2024, included: -check pulse and blood pressure every day and	01950		

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01950	Continued From page 50 report to me in one week. R5's Vitals Summary dated July 1, 2024, through July 22, 2024, indicated R5's blood glucose reading ranged from 86 to 386. R5's Weights and Vitals Summary dated July 1, 2024, through July 23, 2024, indicated R5's -blood pressure ranged from 96/48 to 138/77 -pulse ranged from 54 to 77. On July 23, 2024, at 2:14 p.m., CNS-C stated there were no specific instructions in R5's record regarding blood glucose readings. CNS-C said the doctor did not order when to report blood glucose levels. CNS-C stated R5's record did not include specific instructions for blood pressure and pulse monitoring, adding the medical provider reviewed reading often. CNS-C confirmed R5's record did not include specific instructions as required. The licensee's Medication and Treatment Administration policy dated May 30, 2023, noted when administration of treatment/therapy is delegated or assigned to unlicensed personnel, the facility would ensure that the registered nurse had specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 51 (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 one of one resident (R5) with hospital-style bed rails. 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: R5's diagnoses include diabetes, and hypertension (HTN/high blood pressure,) shortness of breath, Alzheimer's disease, morbid (severe) obesity, and malaise. On July 23, 2024, at 11:33 a.m., the surveyor observed unlicensed personnel (ULP)-D check R5's blood sugar using correct technique while sitting in a chair. R5 had a hospital bed in her room and stated she used the side rails on her bed. R5's record included Focus/Goal/Interventions/Tasks form revised on	02310		

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02310	Continued From page 52 January 8, 2024, included: -tenant (resident) required the use of a supportive device bilateral grab bars to promote independence. R5's Bed Device assessment dated May 2, 2024, noted: Use of a side rail(s) would enable the resident to turn side to side in bed, move up and down in bed, hold self to one side, pull self from lying to sitting position, improve balance in transfers, support self in transfers, exit/enter bed more safely, transfer more safely Education and risk vs benefit reviewed, and consent signed for use of device, yes Bed device education discussed with resident Resident completed a return demonstration of safe use of bed device, yes Measurements 1. zone 1: within rail-4.75" or less, yes 2. zone 2: under the rail, between rail supports, or next to a single rail support 4.75" or less, yes 3. zone 3: between the rail and the mattress 4.75" or less, yes 4. zone 4: under the rail, at the ends of the rail 2 and 3/8' and greater than 60-degree angle, yes. R5's record lacked a comprehensive assessment on the use of an assistive device to include measurements. On July 23, 2024, at 11:11 a.m., clinical nurse supervisor (CNS)-C stated all the bed rail assessment would be the same, the form asked if the measurements were less then .... and I (CNS-C) marked "yes". CNS-C added she "got talked to yesterday" by the regional registered nurse (RN-K). CNS-C confirmed completed bed rail assessments did not include the measurement as required.	02310		

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02310	Continued From page 53 The licensee's Bed Mobility Assist Device policy dated July 18, 2023, noted comprehensive assessment would be completed prior to placing the bed device to ensure appropriate use and decrease resident's risk of injury. Bed devices including half side rails, transfer bars, enable bars, etc. would be measured following FDA (Food and Drug Administration) guidance to ensure appropriate and safe distance in gaps by the device. The Guidance for Industry and FDA (Federal and Drug Administration) Staff: Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006, noted, reducing the risk of entrapment involves a multi-faceted approach that includes bed design, clinical assessment and monitoring, as well as meeting patient, resident, and family needs for vulnerable patients in most health care settings - hospitals, long term care facilities, and at home. Therefore, comprehensive bed safety programs in these settings will likely involve input from manufacturers as well as facility staff. Recognizing that not all hospital beds present a risk of entrapment, and that this risk may vary depending on the patient, FDA encourages manufacturers and facilities to work together to develop bed safety programs to evaluate and, if needed, mitigate entrapment risk. When evaluating the safe use of a hospital bed, component or accessory, manufacturers and caregivers should recognize that the risk for entrapment may increase if a hospital bed system is used for purposes, or used in a care setting, not intended by the manufacturer. Evaluating the dimensional limits of gaps in hospital beds may be one component of a bed safety program which includes a comprehensive plan for patient and	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21937	A. BUILDING: _____ B. WING _____	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATURE'S POINT ASSISTED LIVING	1717 UNIVERSITY DRIVE SE SAINT CLOUD, MN 56304

(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 54 bed assessment. FDA recommends that healthcare facilities conduct a risk-benefit analysis to ensure that steps taken to mitigate the risk of entrapment do not create different, unintended risks or reduce clinical benefits available to patients using legacy beds. Such steps may include checking with bed system manufacturers to identify compatible mattresses, rails, and accessories. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". No further information provided. TIME PERIOD OF CORRECTION: Two (2) days	02310		

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164
651-201-4500

Type: Full
Date: *07/22/24*
Time: 10:45:47
Report: 1037241149

Food and Beverage Establishment Inspection Report

Location:
Nature'S Point Assisted Living
1717 University Drive Se
St Cloud, MN56304
Sherburne County, 71

Establishment Info:
ID #: 0039025
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202587027
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C3 ***** Priority 1 *****

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

QUATERNARY AMMONIUM SANITIZING SOLUTION IN THE WIPING CLOTH BUCKET MEASURED 0 PPM. MAINTAIN THE QUATERNARY AMMONIUM SANITIZING SOLUTION BETWEEN 200 AND 400 PPM.

Comply By: 07/22/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

PROVIDE A SIGN OR POSTER AS DESCRIBED ABOVE AT THE HANDWASHING SINK IN THE SERVING KITCHEN.

Corrected on Site

Surface and Equipment Sanitizers

Quaternary Ammonia: = 0 at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: Yes

Food and Equipment Temperatures

Type: Full
Date: *07/22/24*
Time: 10:45:47
Report: 1037241149
Nature'S Point Assisted Living

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK JUG
Violation Issued: No

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

FOODS ARE STORED AND PREPARED IN THE KITCHEN LICENSED FOR SKILLED NURSING SERVICES UPSTAIRS. FOOD SENT DOWN TO THE ASSISTED LIVING SERVING KITCHEN ARE SENT DOWN AT THE TIME OF SERVICE. DISCUSSED PROCEDURES, MENU, BARE HAND CONTACT, AND EMPLOYEE ILLNESS RECORDING WITH MARK AND JORDAN. DISCUSSED ORDERS WITH JORDAN.

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 1037241149 of 07/22/24.

Certified Food Protection Manager: MARK B SMITH

Certification Number: 111162 Expires: 05/03/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
JORDAN HANSEN

Signed: Michelle L Hovanes
Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037241149

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 07/22/24
Time In 10:45:47
Time Out

Nature'S Point Assisted Living	Address: 1717 University Drive Se	City/State: St Cloud, MN	Zip Code: 56304	Telephone: 3202587027
License/Permit #: 0039025	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	X	
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	IN	OUT	N/A	(N/O)	Food separated and protected		
16	IN	(OUT)		N/A	Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

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

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

GOOD RETAIL PRACTICES

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

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

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

					COS	R
Proper Use of Utensils						
43				In-use utensils: properly stored		
44				Utensils, equipment & linens: properly stored, dried, & handled		
45				Single-use/single service articles: properly stored & used		
46				Gloves used properly		
Utensil Equipment and Vending						
47				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:** 07/22/24

Inspector (Signature) Michelle L Hoversos