STATE LICENSING COMPLIANCE REPORT

Report #: HL30661001C

Date Concluded: October 8, 2021

Name, Address, and County of Facility Investigated:
Kingsway Retirement Living
815 West Main Street
Belle Plaine, MN 56011
Scott County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Erin Johnson-Crosby, RN, Rapid Response Evaluator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	C 09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL#30661015 On September 21, 2021, through September 27, 2021, the Minnesota Department of Health conducted a survey ath the above provider, and the following correction orders are issued. At the time of the survey, there were 74 residents receiving services under the provider's Assisted Living with Dementia Care license. In addition, on September 21, 2021, the Minnesota Department of Health conducted an investigation of complaints HL30661001C and HL30661004C. The following correction orders are issued for HL30661001C, tag identification 0470, 0730, 1330, 1480, 1620, 1640, 1710, 1740 and 1760. The following correction order is issued for	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left colunn is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 HL30661004C, tag identification 0700.	0 000		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed, implemented, and evaluated for appropriateness of staffing levels as required,	0 470		

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0 470	Continued From page 2 potentially affecting all of the 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility's staff plan dated October 2020, indicated the number of full time employees it required; however, it did not identify if the plan was for a day, month or year. The staff plan did not include how the plan was developed or implemented to ensure sufficient staffing was met for all residents' needs. On September 23, 2021, at 4:09 p.m. registered nurse (RN)-E stated a staffing plan and evaluation should be completed per the new state regulation. On September 23, 2021, at 5:33 p.m. the licensed assisted living director (LALD) confirmed the only documentation for a staffing plan was the document that was provided. A staff planning policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		

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0 700 SS=G	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to protect one of one resident record (R7) against tampering with record review. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a 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: R7's diagnoses included hypothyroidism (under active thyroid), insomnia, and pain. R7's service plan dated August 12, 2021, indicated the resident received services which included medication administration, transferring, toileting, dressing and grooming. R7's prescriber orders were signed on September 10, 2021, which included an order for oxycodone	0 700		

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0 700	Continued From page 4 (narcotic pain reliever) 5 milligrams (mg) daily. An email received on September 22, 2021, at 12:31 p.m. from a Minnesota Department of Health (MDH) triage specialist identified a nurse practitioner (NP) was at the facility and found documents with her name forged. On September 22, 2021, at 1:43 p.m. the NP stated she looked through R7's record and noticed the signature on the prescriber orders was not hers. The NP reported this to the administrator and to the pharmacy. On September 23, 2021, at 4:09 p.m. the licensed assisted living director (LALD) verified the NP reported the forged physician orders to the facility and they were investigating the issue. The LALD stated staff were questioned and denied forging the physician orders. The LALD stated she had not yet gone through other residents' records to see if this was a pattern. A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal	0 730		

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0 730	Continued From page 5 representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status.	0 730		

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0 730	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure documentation of services had been provided as identified in the service plan for six of six residents (R2, R3, R7, R8, R9 and R19) with records reviewed. In addition, the facility failed to complete a discharge summary for one of one resident (R5) with discharge record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 September 21, 2021, during the entrance conference, registered nurse (RN)-B and RN-E indicated the service plans and assessments were on paper and located in the residents' records. RN-B and RN-E did not know how unlicensed personnel (ULP) documented services provided to residents. R2 R2's record lacked evidence to indicate bathing assistance had been provided as identified on the resident's service plan. R2's service plan dated September 28, 2020, indicated the resident would be provided, but not limited to, bathing assistance weekly. R2's undated 90-day assessment indicated the resident required assistance of one with bathing,	0 730		

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0 730	Continued From page 7 and there were no changes to the services the resident received. R2's record lacked documentation to indicate bathing assistance had been provided, as identified on the resident's service plan. R3 R3's record lacked documentation to indicate AM/PM cares including dressing, hygiene/grooming assistance and continence assistance had been provided as identified on the resident's service plan. R3's service plan dated July 3, 2019, indicated the resident would be provided, but not limited to, the following services: AM/PM cares including dressing, hygiene/grooming assistance, and continence assistance with assist of one to the bathroom AM/PM, after meals and as needed throughout the day and night. R3's undated 90 day assessment, indicated the resident required assistance with dressing, grooming, bathing, and transferring, and there were no changes to the services the client received. R3's record lacked documentation to indicate dressing, hygiene/grooming and continence assistance had been provided as identified on the resident's service plan. R7 R7's service plan dated August 12, 2021, indicated the resident received services which included medication administration, transferring, toileting and dressing and grooming.	0 730		

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0 730	Continued From page 8 R8 R8's undated and unsigned service plan, indicated the resident received services which included medication administration, bathing, activities of daily living (ADL) and transfer assistance. R9 R9's service plan dated August 30, 2021, indicated the resident received services which included medication administration. R19 R19's service plan dated July 30, 2021, indicated the resident received services which included medication administration, and bathing. On September 22, 2021, at 1:30 p.m. ULP-D stated agency staff did not have access to the resident's electronic record to document services provided, and there was no other way for staff to document. On September 23, 2021, at 12:03 p.m. ULP-E stated she has provided direct cares for the past month, and did not have access to the electronic record to document services provided. On September 23, 2021, at 2:30 p.m. documentation of services provided for R7, R8, R9, and R19 were requested, but not provided. On September 23, 2021, at approximately 4:10 p.m. RN-E stated documentation of services provided by staff should be in the resident's record.	0 730		

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0 730	Continued From page 9 Discharge Summary R5's diagnoses included, but were not limited to, dementia (memory loss), diabetes type II (condition that affects the way the body processes blood sugar), and hypertension (high blood pressure). R5 discharged from the facility on August 30, 2021. R5's record lacked a discharge summary; however, when requested by the surveyor, a discharge summary was provided and dated September 21, 2021. On September 23, 2021, at 4:12 p.m. RN-E confirmed the discharge summary had not been completed until it was requested by the surveyor. RN-E further indicated the discharge summary should be done as soon as possible. The licensee's policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
01330 SS=D	144G.60 Subd. 4 Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed	01330		

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01330	Continued From page 10 in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure two of three unlicensed personnel (ULP-D and ULP-E) completed training and competency evaluations in all required training topics with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D ULP-D had a hire date of August 1, 2021, as an employee that would not provide direct cares; however, ULP-D had provided direct cares and administered medications throughout the month of September 2021. On September 21, 2021, at 2:34 p.m. ULP-D	01330		

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01330	Continued From page 11 stated she provided direct cares and administered medications during the month of September 2021. ULP-D stated she worked throughout the entire building and assisted as needed. In addition, ULP-D stated she had not received training or competencies regarding direct care or medication administration. ULP-D's record lacked documentation the employee had successfully completed training and demonstrated competency in all of the required areas. ULP-E ULP-E had a hire date of August 1, 2021, as an employee that would not provide direct cares; however, ULP-E provided direct cares throughout September 2021. ULP-E's record lacked documentation the employee had successfully completed training and demonstrated competency in all of the required areas. On September 21, 2021, at 1:46 p.m. ULP-E stated during the past month she provided direct cares due to short staffing, and provided cares throughout the entire building wherever she was needed. ULP-E stated she had not received training or competencies for direct cares. On September 22, 2021, at 2:30 p.m. registered nurse (RN)-B verified ULP-D and ULP-E's record lacked evidence of completed training and competency testing in all required training topics. On September 23, 2021, at 4:09 p.m. RN-E stated training and competency testing should be completed before providing care or delegated	01330		

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01330	Continued From page 12 nursing tasks, such as passing medications. On September 23, 2021, at 5:33 p.m. the licensed assisted living director (LALD) stated staff should be trained before providing direct care or administering medications, but the facility was in a difficult and challenging position related to staff shortage. The facility's Competency Training Evaluations policy dated September 13, 2021, indicated required training topics in 144G.61, subdivision 2 should be completed prior to the delegation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01480 SS=E	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided for four of four employees (unlicensed personnel (ULP)-E, ULP-B, ULP-D and registered nurse (RN)-D) with records reviewed. This practice resulted in a level two violation (a	01480		

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01480	Continued From page 13 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-E ULP-E had a hire date of August 1, 2021, as an employee that would not provide direct care. On September 21, 2021, at 1:46 p.m. ULP-E stated during the past month, she had provided direct care throughout the entire building wherever she was needed due to short staffing. ULP-E further stated she had not received orientation of resident needs and she just "winged it." ULP-E stated the facility did not put her on the master schedule, but she was expected to provide cares. ULP-B ULP-B started providing direct care for the licensee via a contracted supplemental staffing agency on September 20, 2021. ULP-B's record lacked documentation she had been oriented to individual residents before providing direct cares. On September 22, 2021, at 7:39 a.m. ULP-B stated she had asked for help to identify the residents from another staff member, and give direction on cares. ULP-D ULP-D had a hire date of August 1, 2021, as an employee that would not provide direct care. On September 23, 2021, at 2:34 p.m. ULP-D stated she had passed medications and provided	01480		

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	30661	A. BUILDING: _____ B. WING _____	C 09/27/2021

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01480	Continued From page 14 direct care throughout the month of September 2021, but did not receive orientation to individual residents before providing direct cares. RN-D RN-D started providing direct care via a contracted supplemental staffing agency on September 21, 2021. RN-D's record lacked documentation she had been oriented to individual residents before providing direct cares. On September 22, 2021, at 7:39 a.m. RN-D stated she had asked for help to identify the residents from another staff member for their medications, but didn't know the residents' routines or care needs. On September 23, 2021, at 3:10 p.m. RN-A stated resident orientation was completed when staff were trained. RN-A stated new staff were mentored by another staff person. On September 23, 2021, at 4:09 p.m. RN-E stated new staff should be oriented to residents before providing direct care. The facilities Orientation of Staff and Supervisors & Content policy dated September 13, 2021, indicated staff providing assisted living services must be orientated specifically to each individual resident and services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01480		

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01620	Continued From page 15	01620		
01620 SS=F	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the registered nurse (RN) conducted ongoing client monitoring and reassessments, not to exceed 90 calendar days from the last assessment for eight of eight residents (R1, R2, R3, R4, R7, R8, R9, and R19) with records reviewed. This practice resulted in a level two violation (a	01620		

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01620	Continued From page 16 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: R1 R1's diagnoses included, but were not limited to Parkinson's disease (A disorder of the central nervous system that affects movement, often including tremors) and glaucoma (a condition of increased pressure within the eyeball, causing gradual loss of sight.) R1's service plan dated September 23, 2021, indicated the resident received services including medication administration. On September 22, 2021, at approximately 8:17 a.m. unlicensed personnel (ULP)-A was observed to administer R1's morning medications. R1's last two assessments were requested. A comprehensive home care assessment dated March 9, 2021, and another undated 90-day assessment was provided. R2 R2's diagnoses included, but were not limited to diabetes and heart failure (A chronic condition in which the heart doesn't pump blood as well as it should.) R2's service plan dated September 28, 2020,	01620		

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01620	Continued From page 17 indicated the resident received services including medication administration and weekly bathing assistance. On September 22, 2021, at approximately 11:30 a.m. ULP-A was observed to administer R2's 11:30 a.m. medications. R2's last two assessments were requested. A resident assessment dated March 27, 2015, and another undated 90-day assessment was provided. R3 R3's diagnoses included, but were not limited to, anemia (lack of red blood cells), anxiety, bilateral osteoarthritis of knees (form of arthritis), chronic tremor (shaking movement in one or more parts of the body), edema (swelling caused by excess fluid trapped in tissue), and hypertension (high blood pressure). R3's service plan dated July 3, 2019, indicated the resident received services including medication administration, therapeutic ambulation, transfer and mobility escorts. R3's last two assessments were requested. A 14-day assessment dated July 17, 2019, and another 90 day undated assessment was provided. R4 R4's diagnoses included, but were not limited to dementia (memory disorder), asthma (a condition affecting the lungs causing breathlessness, chest tightness, and coughing) and anxiety (feeling of uneasiness, fear and worry). R4's service plan dated September 28, 2020,	01620		

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01620	Continued From page 18 indicated the resident received services including medication administration, transfer assist and mobility escorts. R4's last two assessments were requested, a 90 day assessment dated June 3, 2019, and another undated 90 day assessment was provided. On September 23, 2021, at 4:12 p.m. RN-E stated when assessments are completed, they should include the nurse's signature and date. RN-E verified all of the 90 day reassessments were lacking the dates of completion. R7 R7's diagnoses included hypothyroidism (under active thyroid), insomnia, and pain. R7's service plan dated August 12, 2021, indicated the resident received services including medication administration, transferring, toileting and dressing and grooming. R7's last two assessments were requested, but were not provided. R8 R8's diagnoses included seizure disorder, and traumatic brain injury and chronic pain. R8's undated and unsigned, service plan indicated the resident received services including medication administration, bathing, activities of daily living (ADL) and transfer assistance. R8's last two assessments were requested, but not provided.	01620		

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01620	Continued From page 19 R9 R9's diagnoses included major depression, acute pain, and muscle spasms. R9's service plan dated August 30, 2021, indicated the resident received services including medication administration. R9's last two assessments were requested, but not provided. R19 R19's diagnoses included congestive heart failure (CHF), tachycardia (high heart rate), pain, and anxiety. R19's service plan dated July 30, 2021, indicated the resident received services including medication administration, and bathing. R19's last two assessments were requested, but not provided. On September 23, 2021, at 4:09 p.m. RN-E stated assessments should be completed per regulation, and should be signed and dated when completed. The facility's Assessment Review & Monitoring policy dated September 13, 2021, indicated resident assessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be on as needed based on changes in the needs of resident and cannot exceed 90 calendar days from the last date of the assessment.	01620		

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01620	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=E	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of four resident (R4) service plans were revised to reflect the current services provided. In addition, the facility failed to ensure the service plan included a signature or other authentication by the resident	01640		

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01640	Continued From page 21 and the facility to document agreement on the services provided for four of six residents (R7, R8, R9, and R19) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4 R4's diagnoses included, but were not limited to dementia (memory disorder), asthma (a condition affecting the lungs causing breathlessness, chest tightness, and coughing) and anxiety (feeling of uneasiness, fear and worry). On September 21, 2021, at approximately 3:30 p.m. unlicensed personnel (ULP)-G stated R4 needed assistance with showering, dressing and grooming tasks. ULP-G further included R4 received assistance with toileting and incontinence cares. R4's service plan dated September 28, 2020, did not identify R4 received assistance with bathing, dressing/undressing, hygiene/grooming assistance or toileting assistance. On September 23, 2021, at 4:12 p.m. RN-E stated all service plans should be revised as needed with signatures, and RN-E would expect to see a copy in the chart. R7	01640		

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01640	Continued From page 22 R7's diagnoses included hypothyroidism (under active thyroid), insomnia, and pain. R7's service plan dated August 12, 2021, indicated the resident received services including medication administration, transferring, toileting and dressing and grooming. The service plan was signed by RN-A and indicated verbal consent was given, but it did not include a date, time, or who gave verbal consent. R8 R8's diagnoses included seizure disorder, and traumatic brain injury and chronic pain. R8's undated and unsigned service plan, indicated the resident received services including medication administration, bathing, activities of daily living (ADL) and transfer assistance. The service plan was signed by RN-A and indicated verbal consent was given, but it did not include a date, time, or who gave verbal consent. R9 R9's diagnoses included major depression, acute pain, and muscle spasms. R9's service plan, dated August 30, 2021, indicated the resident received services including medication administration. The service plan was signed by RN-A and indicated verbal consent was given, but it did not include a date, time, or who gave verbal consent. R19 R19's diagnoses included congestive heart failure (CHF), tachycardia (high heart rate), pain, and anxiety. R19's service plan dated July 10, 2021, indicated	01640		

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01640	Continued From page 23 the resident received services including medication administration, and bathing. The service plan was signed by RN-A and indicated verbal consent was given, but did not include a date, time, or who gave verbal consent. In addition, R19's September 2021, medication administration record (MAR) indicated R19 self-administered her medications. On September 23, 2021, at 4:09 p.m. RN-E stated when verbal consent is given it should include who gave verbal consent, date, and a plan to get the service plan signed. The facility's Service Plan Modifications policy dated September 13, 2021, indicated when a resident receives assisted living services and a change(s) to the service plan occurs, the service plan must be amended in writing and signed by the resident or the resident's designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01710 SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced	01710		

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01710	Continued From page 24 by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed annual medication reassessments for four of seven residents (R1, R2, R7 and R8) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included, but were not limited to, Parkinson's disease (A disorder of the central nervous system that affects movement, often including tremors) and glaucoma (a condition of increased pressure within the eyeball, causing gradual loss of sight.) On September 22, 2021, at approximately 8:17 a.m. unlicensed personnel (ULP)-A was observed to administer R1's morning medications. R1's service plan dated September 23, 2021, indicated the resident received services including medication administration. R1's record lacked documentation of an annual medication reassessment. The most recent medication assessment was dated March 9, 2020.	01710		

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01710	Continued From page 25 R2 R2's diagnoses included, but were not limited to, diabetes and heart failure (A chronic condition in which the heart doesn't pump blood as well as it should). R2's service plan dated September 28, 2020, indicated the resident received services including medication administration and weekly bathing assistance. On September 22, 2021, at approximately 11:30 a.m. ULP-A was observed to administer R2's 11:30 a.m. medications. R2's record lacked documentation of an annual medication reassessment. The most recent medication assessment was dated October 9, 2018. R7 R7's diagnoses included hypothyroidism (under active thyroid), insomnia, and pain. R7's service plan dated August 12, 2021, indicated the resident received services including medication administration, transferring, toileting and dressing and grooming. R7's last medication assessment was requested, but not provided. R8 R8's diagnoses included seizure disorder, and traumatic brain injury and chronic pain. R8's undated and unsigned service plan,	01710		

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01710	Continued From page 26 indicated the resident received services including medication administration, bathing, activities of daily living (ADL) and transfer assistance. R8's last medication assessment was requested, but not provided. On September 23, 2021, at 4:39 p.m. RN-E confirmed the annual medication reassessment needed to be completed at least yearly and R1, R2, R7 or R8's medication assessments were not updated or current. A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01710		
01740 SS=D	144G.71 Subd. 6 Administration of medication Medications may be administered by a nurse, physician, or other licensed health practitioner authorized to administer medications or by unlicensed personnel who have been delegated medication administration tasks by a registered nurse. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of two unlicensed personnel (ULP-D) had been trained and competency tested prior to delegating administering medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01740		

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01740	Continued From page 27 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D's hire date was August 1, 2021, as an employee that would not provide direct care. Upon review of the second and third floor residents' medication administration records (MAR), it was noted ULP-D had administered medications numerous times throughout the month of September 2021, with the most recent being September 16, 2021. On September 21, 2021, at 2:34 p.m. ULP-D stated she provided direct care and administered medications during the month of September 2021. ULP-D stated she worked throughout the entire building and assisted as needed. ULP-D stated she had not received training regarding medication administration. On September 23, 2021, at 4:09 p.m. registered nurse (RN)-E stated training and competency testing should be completed before administering medications. On September 23, 2021, at 5:33 p.m. the licensed assisted living director (LALD) stated staff should be trained before providing direct care or passing medications, but the facility was in a difficult and challenging position related to staff shortage.	01740		

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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
01740	Continued From page 28 The facility's Competency Training Evaluations policy dated September 13, 2021, indicated only ULP who are determined to be competent and posses the knowledge and skills consistent with the complexity of the tasks being delegated will be permitted to perform delegated tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01740		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medication was administered as prescribed for two of four residents (R4, R3) with records reviewed. In addition, the licensee failed to ensure medication orders were transcribed to the medication administration record (MAR) accurately for one of	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	C 09/27/2021

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01760	Continued From page 29 one resident (R18) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of resident's 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: MEDICATIONS NOT GIVEN AS PRESCRIBED R4 R4's diagnoses included, but were not limited to, dementia (memory disorder), asthma (a condition affecting the lungs causing breathlessness, chest tightness, and coughing) and anxiety (feeling of uneasiness, fear and worry). R4's service plan dated September 28, 2020, indicated the resident received services which included medication administration. R4's prescriber orders dated August 12, 2020, included the following medications: Seroquel (antipsychotic) 25 milligrams (mg) by mouth four times a day; Tylenol (non-narcotic pain reliever) 325 mg 3 tablets by mouth three times a day; divalproex sodium (anticonvulsant)125 mg 2 capsules by mouth three times a day; A review of the September 2021 medication administration record (MAR), indicated R4's medication record lacked documentation of administered medications for the following dates:	01760		

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01760	Continued From page 30 Seroquel - PM and HS (hour of sleep) dose on September 15, 2021 Tylenol - Afternoon and HS dose on September 15, 2021 divalproex sodium -HS dose on September 15, 2021 R3 R3's diagnoses included, but were not limited to, anemia (lack of red blood cells), anxiety, bilateral osteoarthritis of knees (form of arthritis), chronic tremor (shaking movement in one or more parts of the body), edema (swelling caused by excess fluid trapped in tissue), and hypertension (high blood pressure). R3's service plan dated July 3, 2019, indicated the resident received services which included medication administration. R3's prescriber orders dated November 18, 2020, included the following medications: Nystatin powder (antifungal) apply to affected areas in groin twice a day; clonazepam (antianxiety, antiepileptic) 1 mg by mouth three times a day; acetaminophen 500 mg 2 tablets by mouth three times a day; multiple vitamin-minerals (supplement) 1 capsule by mouth daily; A review of the September 2021, MAR indicated R3's medication record lacked documentation of administered medications for the following dates: Nystatin powder -AM dose on September 4, 7, 8, and 16, 2021 -2000 dose on September 16, 2021 clonazepam -1900 dose on September 6, 2021	01760		

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01760	Continued From page 31 acetaminophen -1900 dose on September 6, 2021 multiple vitamin-minerals -1900 dose on September 6, 2021 On September 24, 2021, at 2:32 p.m. registered nurse (RN)-A confirmed both R3 and R4's medication record lacked documentation of administration for the above listed dates. RN-A further verified without a signature there was no proof the medications were administered, nor was there alternative documentation of why it wouldn't have been given. The facility's 7.22 Medication & Treatment Record Documentation & Refusal policy dated September 1, 2021, indicated the signature and title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy would be documented in the residents records after providing medication assistance or administration. The policy also included any refusal of medication would be documented on the MAR. TRANSCRIPTION ERROR R18's Physician Orders dated June 20, 2021, included, but was not limited to: cephalexin (antibiotic) 500 mg by mouth twice a day AM and PM x seven (7) days with the first date: March 8, 2021, for genitourinary infection. DC (discontinue) was written to the side of this order and signed by the physician. R18's MAR dated September 2021, included, but was not limited to:	01760		

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01760	Continued From page 32 - cephalexin 500 mg by mouth twice a day AM and PM x 7 days. On September 22, 2021, at 8:30 a.m. RN-D was observed to prepare R18's morning medications. The MAR included an order for cephalexin as noted above. RN-D double checked that there were no more medications for the client, then stated it looked like an old order that should have been discontinued, and not on the current MAR. RN-D further stated she would need to look into this order as to why it was still on current MAR. On September 23, 2021, at 4:12 p.m. RN-E stated the order should have been transcribed into the MAR to include a start and end date, and it had not been transcribed as ordered. The facility's 7.16 Medications & Treatment Orders- Implementing dated September 13, 2021, lacked instruction on transcribing orders. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		