Electronically delivered

January 10, 2022

Administrator
Talamore Senior Living
215 37h Avenue North
Saint Cloud, MN 56303

RE: Project Number(s) SL34875015-1

Dear Administrator:

On January 5, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on October 21, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the October 21, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 21, 2021, found not corrected at the time of the January 5, 2022 follow-up evaluation and subject to penalty assessment are as follows:

0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) - $500.00
1700-Provision Of Medication Management Services-144g.71 Subd. 2 - $500.00

The details of the violations noted at the time of this follow-up evaluation completed on January 5, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on January 5, 2022, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5

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

DOCUMENTATION OF ACTION TO COMPLY

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

respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 16, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

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

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	R 01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34875015 On January 4, 2022, through January 5, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 21, 2021. At the time of the survey, there were 56 active residents receiving services under the Assisted Living Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a survey completed on October 21, 2021, 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 340		

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0 340	Continued From page 2 of the residents). The findings include: On January 4, 2022, at approximately 10:30 a.m., senior housing portfolio director (SHPD)-P and registered nurse (RN)-Q stated they felt the corrections had been made, to the best of their knowledge. During the revisit survey on January 4, 2022, through January 5, 2022, a review of the licensee's policies and procedures, resident records, employee records, and interviews lacked evidence to indicate the licensee had corrected all the orders issued on October 21, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	{0 480}		

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{0 480}	Continued From page 3 This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 810} 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	{0 810}		

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{0 810}	Continued From page 4 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{01640} SS=C	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 interview and record review, the licensee failed to ensure the service plan	{01640}		

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{01640}	Continued From page 5	{01640}		

revisions included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for four of four residents (R8, R9, R10 and R11) with records reviewed.

This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a 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:

R8, R9, R10 and R11's Service Plan Agreement revisions lacked a signature or other authentication by the resident and by the facility, as required.

R8
R8's Service Plan Agreement dated September 17, 2021, indicated R8 received services including assistance with activities of daily living.

R9
R9's Service Plan Agreement dated August 2, 2021, indicated R9 received services including assistance with activities of daily living.

R10
R1's Service Plan Agreement dated February 8, 2021, indicated R10 received services including assistance with activities of daily living.

R11
R11's Service Plan Agreement dated August 10,

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{01640}	Continued From page 6 2021, indicated R11 received services including assistance with activities of daily living. On January 5, 2021, at approximately 11:00 a.m., senior housing portfolio director (SHPD)-P stated the licensee sent out an addendum with the November statements to all residents/representatives to include the required verbiage on the schedule and methods of monitoring assessments of the resident and the methods of monitoring staff providing services. SHPD-P confirmed with registered nurse (RN)-H no documentation had been made in the resident records, and no signature had been obtained after this revision was completed. The licensee's Contents of Service Plans policy, dated July 28, 2021, noted the service plan and any revisions would have a signature or other authentication by the facility and the resident. No further information was provided.	{01640}		
{01700} SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and	{01700}		

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{01700}	Continued From page 7	{01700}		

identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.
(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

This MN Requirement is not met as evidenced by:
Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment to determine what medication management services would be provided and how the services would be provided for three of three residents (R9, R10 and R11) with records reviewed.

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

The findings include:

During the revisit entrance conference on January 4, 2021, at approximately 10:30 a.m.,

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{01700}	Continued From page 8 senior housing portfolio director (SHPD)-P and registered nurse (RN)-Q stated the licensee provided medication management services to residents. R9, R10 and R11's records lacked evidence the RN conducted a medication assessment to include: - an identification and review of all medications the resident was known to be taking. R9 R9's Service Plan Agreement dated August 2, 2021, indicated R9 received services including assistance with activities of daily living. R9's Medication management plan, addendum to the service plan, dated November 3, 2021, indicated services to include medication administration, and noted after review of the resident's current medication profile, no contraindications, side effects, allergies or adverse reactions were noted. However, the plan failed to identify the source of the medication profile. R9's December 2021, Medication Sheet, listed the medications as prescribed, times to administer, and staff initials indicating the medications had been administered. R9's prescriber orders, print date January 4, 2022, included one pain reliever and one antidepressant. R10 R1's Service Plan Agreement dated February 8, 2021, indicated R10 received services including assistance with activities of daily living.	{01700}		

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{01700}	Continued From page 9 R10's Medication management plan, addendum to the service plan, dated November 3, 2021, indicated services to include medication administration, and noted after review of the resident's current medication profile, no contraindications, side effects, allergies or adverse reactions were noted. However, the plan failed to identify the source of the medication profile. R10's December 2021, Medication Sheet, listed the medications as prescribed, times to administer, and staff initials indicating the medications had been administered. R10's prescriber orders, print date January 4, 2022, included one diuretic (causes increased passing of urine), and one medication to reduce blood pressure. R11 R11's Service Plan Agreement dated August 10, 2021, indicated R11 received services including assistance with activities of daily living. R11's Medication management plan, addendum to the service plan, dated August 4, 2021, indicated services to include medication administration, and noted after review of the resident's current medication profile, no contraindications, side effects, allergies or adverse reactions were noted. However, the plan failed to identify the source of the medication profile. R11's December 2021, Medication Sheet, listed the medications as prescribed, times to administer, and staff initials indicating the medications had been administered.	{01700}		

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{01700}	Continued From page 10 R11's prescriber orders, print date January 4, 2022, included one anti anxiety medication and one medication to reduce blood pressure. On January 5, 2021, at approximately 11:00 a.m., registered nurse (RN)-Q verified there was no document titled medication profile, as mentioned in the medication management plan, and stated the referenced document was a list compiled by the licensee of the resident's medications. In addition, RN-Q stated the same template was utilized for all residents receiving medication management. The licensee's Medication, Treatment and Therapy Reminders policy dated November 1, 2021, indicated prior to providing any medication, the RN would conduct a nursing assessment of the resident's functional status and need for medication management services, and would develop an individualized medication management plan based on the resident's needs and preferences. No further information was provided.	{01700}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an	{02040}		

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{02040}	Continued From page 11 approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action required.	{02040}		

Electronically Delivered

November 21, 2021

Administrator
Talamore Senior Living
215 37th Avenue North
Saint Cloud, MN 56303

RE: Project Number(s) SL34875015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 21, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

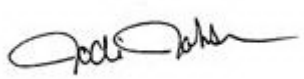
Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

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

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, 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: SL34875015 On October 18, 2021, through October 21, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 37 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1	0 250		

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

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0 250	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 18, 2021, at approximately 9:55 a.m. registered nurse (RN)-A stated she had printed the regulations from on-line to review.	0 250		

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0 250	Continued From page 3 The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - In understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data (opens in a new window), the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets the requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying	0 250		

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0 250	Continued From page 4 a license. I understand that information submitted to the commissioner in the application may, in some circumstances, be disclosed to the appropriate state, federal or local agency, and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license. All data submitted are considered private until MDH issues a license. - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." - "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659	0 250		

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0 250	Continued From page 5 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page five was electronically signed by the owner on May 25, 2021. The licensee had an Assisted Living with Dementia Care license, issued on July 22, 2021. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - orientation to and implementation of the assisted living bill of rights; - infection control practices; - ensuring nurses had current and valid licenses to practice; and - medication and treatment management Refer to licensing order at Statute 144G.63, Subd. 1. The licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of four employees (RN-E and unlicensed personnel (ULP)-D) with records reviewed. Refer to licensing order at Statute 144G.63, Subd. 2. The licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of two employees (RN-A and ULP-C) with records reviewed. Refer to licensing order at Statute 144G.64 (a). The licensee failed to ensure staff completed the	0 250		

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0 250	Continued From page 6 required amount of dementia care training in the required time frame for three of four employees (RN-A, RN-E, ULP-C and ULP-D) with records reviewed. Refer to licensing order at Statute 144G.90. Subd. 1. The licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided and a written acknowledgement was received for two of three residents (R1 and R2) with records reviewed. Refer to licensing order at Statute 144G.41, Subd. 3. The licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. Refer to licensing order at Statute 144G.42, Subd. 8. The licensee failed to maintain a current employee record for each individual contractor providing services for for two of two contracted employees (RN-E and ULP-D) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 2. The licensee failed to ensure the RN conducted an individualized assessment prior to providing medication management services to one of two residents (R2), and failed to determine what medication management services would be provided, and how the services would be provided for two of two residents (R2, R3) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 5. The licensee failed to develop an individualized medication management plan with the required content, for two of two residents (R2,	0 250		

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0 250	Continued From page 7 R3) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 8. The licensee failed to ensure medication was administered as prescribed for one of three residents (R7) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 9. The licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R5 and R6) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 13. The licensee failed to ensure a current written or electronically recorded prescription was obtained for all medications the provider had managed for the one of three residents (R7) with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 2. The licensee failed to develop, implement and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a RN consistent with current practice standards and guidelines, with records reviewed. Twenty-eight (28) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		

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0 430	Continued From page 8	0 430		
0 430 SS=B	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a copy of the uniform disclosure of assisted living services and amenities (UDALSA) with the required content for two of three residents (R1 and R2) with records reviewed. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited	0 430		

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0 430	Continued From page 9 number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: R1 and R2's records lacked evidence of a UDALSA with the following required content: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of all services offered under the contract R1 and R2 began receiving assisted living services on August 1, 2021. R1 R1's Service Plan Agreement dated July 15, 2021, noted services to include assistance with activities of daily living. On October 19, 2021, at approximately 7:50 a.m. unlicensed personnel (ULP)-C and ULP-I were observed to assist R1 with morning cares. On October 20, 2021, at approximately 2:30 p.m. registered nurse (RN)-A and RN-H verified R1 did not receive the UDALSA as listed above.. R2 R2's Service Plan Agreement dated March 25,	0 430		

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0 430	Continued From page 10 2021, noted services to include assistance with activities of daily living. On October 19, 2021, at approximately 8:45 a.m. R2 sat at a table in the dining room, in the facility's memory care unit, eating breakfast with assistance from a hospice staff. On October 20, 2021, at approximately 1:47 p.m. the director of resident services (DNS) stated only a few residents had received the UDALSA effective August 1, 2021, and verified R2 had not received the above required information. A policy related to the uniform disclosure was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480		

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0 480	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared 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, 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated October 18, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(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
0 510	Continued From page 12 control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This deficient practice had the potential to affect all of the licensee's 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: PPE/SCREENING On October 18, 2021, at approximately 9:30 a.m. the receptionist at the front desk (R)-J, did not wear eye protection as she signed in staff and visitors. There were no COVID-19 symptom screening questions for visitors or staff to answer as they signed in at the front desk. The floor stand alcohol-based hand rub (ABHR) dispenser at the lobby entrance was empty.	0 510		

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0 510	Continued From page 13 On October 19, 2021, at approximately 7:30 a.m. unlicensed personnel (ULP)-C screened MDH surveyors for temperatures. There were no COVID-19 symptom screening questions for visitors or staff to answer as they signed in at the front desk. The floor stand ABHR dispenser at the lobby entrance was empty. On October 19, 2021, at 7:58 a.m. ULP-L was observed passing medications to residents in the memory care unit. ULP-L wore a full face shield and a cloth face mask. On October 19, 2021, at 8:05 a.m. ULP-L stated she was not aware that she should be wearing a medical-grade face mask, and indicated no one had ever told her that. ULP-L stated she had always worn a cloth face mask that she washed after each shift. On October 19, 2021, at 9:40 a.m. registered nurse (RN)-A stated her expectation was staff wear medical-grade face masks and eye protection. R-J should wear eye PPE when residents or visitors are at the front desk. COVID SIGNAGE R5's diagnoses included chronic kidney disease stage 4, type 2 diabetes, and hypertension. R5's service plan indicated he received weekly vital signs and housekeeping services. On October 18, 2021, at approximately 10:35 a.m. R5's room lacked signage indicating staff or visitors needed to check in with the nurse before entering the room due to a positive COVID-19 diagnosis. There was no PPE supply box outside of R5's room.	0 510		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

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0 510	Continued From page 14 On October 20, 2021, at 2:30 p.m. RN-A said resident COVID-19 positive statuses were documented in the communication book because she did not want to advertise someone had COVID-19 by putting up signs. The licensee's Coronavirus, Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization policy dated May 7, 2020, indicated: post a notice so all personnel and others in the building are directed to talk to a staff person or nurse prior to entering the room. HAND HYGIENE On October 19, 2021, at approximately 7:50 a.m. ULP-C and ULP-I assisted R1 with personal cares. Both employees were wearing medical-grade facemasks and eye protection. ULP-C applied compression stockings and braces to R1's feet, and placed the catheter bag on R1's left leg. Both ULP removed R1's brief. ULP-C performed perineal cares in the front, and ULP-I in the back. At this point, without removing gloves or performing hand hygiene, ULP-C pulled up the new brief, and changed the gloves; however, no hand hygiene was performed. ULP-C got R1's clothing while ULP-I looked at the work phone. ULP-C and ULP-I pulled up R1's pants, and ULP-I put away powder into R1's drawer, without performing hand hygiene. ULP-C maneuvered R1's motorized wheelchair, touched the joystick, and brought it next to the bed. At this time ULP-C moved the small bedside table. ULP-I removed R1's pajama shirt and placed a bra and new shirt on R1, and placed linen in the cabinet. ULP-C adjusted R1's catheter bag as requested by R1, and touched the bed remote to lower the head of bead. At this time, both ULP transferred R1 into the wheelchair, and attached	0 510		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

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0 510	Continued From page 15	0 510		

the leg straps and seatbelt. ULP-I left the apartment without being observed to perform hand hygiene. At this time, ULP-C was observed to remove the night catheter bag from bedside and bring it to the bathroom, empty the contents into the toilet, and wiped the tip with an alcohol wipe. ULP-C mixed vinegar and water and poured it into the catheter bag, and left it in the bin to soak. ULP-C touched a blue cloth bag which he indicated contained toiletries, and removed the gloves. At this time, ULP-C removed the gloves, left R1's apartment, and performed hand hygiene in the hallway.

When interviewed at this time, ULP-C verified hand hygiene had not been performed until he exited the room, and thought he should have done it after removing the gloves.

On October 19, 2021, at approximately 8:25 a.m. ULP-C and ULP-I were observed repositioning a resident in her recliner type chair in her room. ULP-C and ULP-I assisted the resident by lifting her up in her chair and untangling her blanket. ULP-C and ULP-I exited the resident's room and walked across the hall to the medication room. ULP-C removed his faceshield and drank from a bottle of soda without performing hand hygiene. ULP-I opened the medication cart and began preparing medications for R7 without performing hand hygiene. ULP-I went to R7's room and administered his medication without performing hand hygiene. On the way back to the medication room ULP-I used ABHR at the elevator and stated staff could wash their hands once they returned to the (medication) office.

On October 19, 2021, at approximately 9:50 a.m. RN-A stated she would expect staff to remove gloves and perform hand hygiene after removing

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0 510	Continued From page 16 gloves, and after performing perineal cares and catheter cares. A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all of the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 550		

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0 550	Continued From page 17 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: The licensee lacked a posting of the grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On October 18, 2021, during the facility tour at approximately 10:40 a.m., the surveyor observed the entry area and common areas within the facility, and noted there was no required posting of the grievance procedure and contact information for the state and applicable regional Office of the Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On October 20, 2021, at approximately 2:05 p.m. the director of resident services (DRS) stated residents received the grievance procedure in their admission packets and discussed the procedure at resident council meetings; however, the DRS confirmed the required content noted above was not currently posted as required. The licensee's Complaint Policy and Procedure dated July 20, 2021, lacked direction to post the above information as required.	0 550		

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0 550	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for three of three residents (R1, R2 and R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 630		

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0 630	Continued From page 19 The findings include: R1, R2, and R3's records lacked an individual abuse prevention plan to include the person's susceptibility to abuse by other individuals. In addition, R1's record lacked statements of the specific measures to be taken to minimize the risk of abuse. R1 On October 19, 2021, at approximately 7:50 a.m. unlicensed personnel (ULP)-C and ULP-I were observed to assist R1 with morning cares. R1's Service Plan Agreement dated July 15, 2021, noted services included assistance with activities of daily living. R1's Individual Abuse Prevention Plan dated August 5, 2021, noted vulnerabilities included, but were not limited to, the following: - range of motion limitations, noting due to paraplegia and spasms; - vulnerability related to endurance/strength, noting weakness due to recent hospitalization; - impaired sense of touch or smell, noting paraplegia after accident 3 plus years ago; and - ability to maintain a safe/clean environment, noting needs assistance On October 20, 2021, at approximately 2:30 p.m. registered nurse (RN)-A confirmed R1's abuse prevention plan lacked information on the resident's susceptibility to abuse by other individuals, and the statements of specific measures to be taken related to the identified vulnerabilities. R2	0 630		

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0 630	Continued From page 20 On October 19, 2021, at approximately 8:45 a.m. R2 sat at a table in the memory care unit dining room, eating breakfast with assistance from a hospice staff. R2's Service Plan Agreement dated March 25, 2021, noted services included assistance with activities of daily living. R2's Individual Abuse Prevention Plan dated April 6, 2021, indicated R2 had some identified areas of potential vulnerabilities and included interventions designed to address the areas of vulnerability, had no signs of abuse or neglect, and did not appear to pose a threat to other vulnerable adults; however, the plan lacked information on R2's susceptibility to abuse by other individuals. R3 On October 19, 2021, at 1:50 p.m. R3 was observed seated in his room watching TV. R3 stated he liked living at the facility and received cares, but could not recall what they were. R3 stated he had a call pendant and when he needed something he pushed it and staff would come to help him. R3's Service Plan Agreement dated September 5, 2021, noted services included assistance with activities of daily living. R3's Individual Abuse Prevention Plan dated September 6, 2021, indicated R3 had some identified areas of potential vulnerabilities and included interventions designed to address the areas of vulnerability, had no signs of abuse or neglect, and did not appear to pose a threat to other vulnerable adults; however, the plan lacked	0 630		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

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0 630	Continued From page 21 information on R3's susceptibility to abuse by other individuals. On October 20, 2021, at approximately 2:35 p.m. RN-H confirmed R2 and R3's abuse prevention plan lacked information on the resident's susceptibility to abuse by other individuals, and confirmed the same format was utilized for all clients. The licensee's Development of Individual Abuse Prevention Plans policy dated July 26, 2021, noted the individual abuse prevention plan would include an individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults, and specific measures to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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	0 640		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

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0 640	Continued From page 22 (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all of the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility. On October 18, 2021, during the facility tour at approximately 10:40 a.m. the surveyor observed the entry area, common areas, and medication rooms/charting areas within the facility, and noted there was no required posting of the 911 emergency number, as required. On October 20, 2021, at approximately 2:55 p.m. registered nurse (RN)-H confirmed the 911 emergency information was not posted, as	0 640		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

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0 640	Continued From page 23 required. The licensee's Resident Emergencies/911 Calls policy dated July 22, 2021, directed staff discovering an emergency should immediately call the licensed nurse onsite. If no nurse was immediately available onsite, staff should promptly call 911. The policy lacked direction to post the 911 emergency number in common areas and near telephones. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

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0 650	Continued From page 24 and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain a current employee record for each individual contractor providing services for for two of two contracted employees (registered nurse (RN)-E and unlicensed personnel (ULP)-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on October 18, 2021, at approximately 9:55 a.m. RN-A stated the licensee used a supplemental staffing agency to meet their staffing needs for ULP, and had contracted on-call nurses to cover for 7:00 p.m. to 7:00 a.m.	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

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TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

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0 650	Continued From page 25 RN-E RN-E had a start date of August 1, 2021, as a contracted nurse to provide on-call services as needed. RN-E's record lacked the following required content: - evidence of current professional licensure; - records of orientation, infection control training, and competency evaluations; - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings A copy of RN-E's license was obtained, with an expiration date of April 30, 2022. ULP-D ULP-D worked with a temporary staffing agency contracted by the licensee. ULP-D's record lacked the following required content: - records of orientation, infection control training, and competency evaluations; - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; - for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and -documentation of the background study as required under section 144.057.	0 650		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

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0 650	Continued From page 26 On October 18, 2021, at approximately 10:50 a.m. ULP-D was observed in the medication room on the second floor charting. On October 20, 2021, at approximately 8:53 a.m. business office manager (BOM) stated RN-E only took call for the building from 7:00 p.m. to 7:00 a.m., and was never in the building. On October 20, 2021, at approximately 12:50 p.m., BOM provided evidence of a background study for RN-E, and confirmed there was no employee record for RN-E or ULP-D with the above required content. The licensee's Personnel Records policy dated July 29, 2021, noted a personnel record would be maintained for each individual contractor providing home care services, and would include: - evidence of current professional licensure; - record of home care orientation; - record of all required training for ULP and competency determinations; - record of all required in-service education for all staff providing home care services to clients; - documentation of a completed criminal background study; - tuberculosis screening results; - results of supervision observations; and - current job description, including qualifications, responsibilities and identification of supervisors No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 27 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to have a written emergency preparedness (EP) plan with all of the required content and failed to post an emergency preparedness plan prominently. In addition, the licensee failed to provide building emergency exit diagrams to all residents. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 680		

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0 680	Continued From page 28 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the initial tour on October 18, 2021, at approximately 10:40 a.m. the facility's layout included one large building with four levels, with resident apartments. The main level included the main entrance, kitchen, dining room, several gathering spaces for residents and visitors, activity area, staff offices, and a secured memory care unit. Each of the other levels included resident apartments, gathering spaces, and staff offices. Although emergency exit diagrams were posted by stairwells on each floor and posted in assisted living and independent living residents' apartments on the inside of their apartment door, there was no evidence of signage posted or information regarding the licensee's emergency plan. In addition, there was no evidence emergency exit diagrams were provided to the residents living in the memory care unit, as required. The EP plan was located in a red binder dated August 1, 2021, located at the reception desk on the main level and indicated the executive director (ED) was responsible for maintaining an effective and current emergency preparedness plan and implementing procedures. In addition, all staff members were to be provided training upon orientation and at a minimum on an annual basis as it related to the EP plan, and were	0 680		

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0 680	Continued From page 29 responsible for understanding the scope of the emergency plan and the role(s) they play in implementing the procedures. The plan included a brief hazard & vulnerability summary, which identified fire, mass casualty (internal and external), chemical spill, weather related events, civil disturbance, train derailment, and bomb threat as probable events, and included rapid response guides for each of these identified events. In addition, the plan included a list of policies and procedures on page 10 and 11, that were included in the Emergency Preparedness Plan, including but not limited to evacuation, dietary and water needs, transfer agreements, loss of power, infectious disease outbreak, medical records, communication plan, security, and shelter in place; however, these policies were not found in the plan. The Emergency Preparedness Plan lacked the following required content: - a comprehensive program to include infectious diseases and pandemics; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies including surge planning and use of volunteers; - the facility's role in providing care and treatment at alternative sites; - a communication plan that included: - arrangement with other facilities;	0 680		

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0 680	Continued From page 30 - names and contact information for staff, resident physicians, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents - a means to provide information regarding the facility's needs, and the ability to provide assistance to include information about their occupancy; -a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On October 21, 2021, at approximately 9:05 a.m. the maintenance director (MD) stated he was involved in the development of the emergency preparedness plan, but deferred questions to the ED. The MD stated no testing of the plan had been completed; however, there was a severe thunderstorm this summer, and residents came out of their apartments, not knowing what to do. The MD stated there was no documentation of this event. In addition, the MD verified emergency exit diagrams were not provided to residents in the memory care unit. On October 21, 2021, at 9:30 a.m. the business office manager and registered nurse (RN)-A stated staff had not been trained on the Emergency Preparedness Plan dated August 1, 2021.	0 680		

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0 680	Continued From page 31 On October 21, 2021, at approximately 10:15 a.m. the ED provided an updated Emergency Preparedness Plan dated September 15, 2021, and stated this was the complete plan. When asked about the location of the policies that were listed, the ED stated, "This is all there is." The licensee lacked policies regarding emergency preparedness. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous	0 730		

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0 730	Continued From page 32 assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the client record included the required content for one of three residents (R1) 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	0 730		

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0 730	Continued From page 33 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record lacked documentation of communication with an outside provider for wound care treatment. On October 19, 2021, at approximately 7:50 a.m. unlicensed personnel (ULP)-C and ULP-I were observed to assist R1 with morning cares. R1's Service Plan Agreement dated July 15, 2021, noted services included assistance with activities of daily living. R1's Progress Note dated August 30, 2021, authored by registered nurse (RN)-A, noted home care continued to follow R1 with visits every other day to monitor her catheter, colostomy, wounds to abdomen and feet, and also noted R1 went to the wound center often. R1's Uniform Assessment Tool dated September 1, 2021, identified the resident had a wound to the left foot and a wound on the abdomen, and indicated another provider was completing the dressing changes. On October 20, 2021, at approximately 2:30 p.m. RN-A confirmed R1's record lacked documentation on the status of the resident's wounds. The licensee's Resident Records policy dated July 28, 2021, noted the resident record would include relevant health records and all records of communications pertinent to the resident's assisted living services.	0 730		

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0 730	Continued From page 34 No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty one (21) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810		

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0 810	Continued From page 35 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation of policy, schedule, and log of staff and resident training for fire safety and evacuation procedures. The fire safety and evacuation plan failed to show procedures for resident movement, evacuation, or relocation during a fire or similar emergency. Plan does not include the identification of unique or unusual resident needs for movement or evacuation. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 18, 2021, at approximately 11:30 a.m. while reviewing emergency preparedness procedures, no evidence was provided for the required twice per year staff training or once per year resident training. The plan also did not include specific information on 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. On October 18, 2021, at approximately 11:35	0 810		

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0 810	Continued From page 36 a.m. the maintenance director confirmed the facility had not developed a plan or schedule for required employee and resident training. A policy related to a plan for required training of employees and training of residents was requested, but not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed.	0 900		

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0 900	Continued From page 37 (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for two of three residents (R1 and R2) and failed to offer the resident the opportunity to identify a designated representative for one of three residents (R3) with records reviewed. In addition, the licensee failed to offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care, a complete unsigned copy of its contract. 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:	0 900		

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0 900	Continued From page 38 The licensee failed to provide an unsigned copy of its contract as required to: - the Office of Ombudsman for Long-Term Care; and - prospective residents On October 20, 2021, at approximately 1:55 p.m., business office manager (BOM) and director of resident services (DRS) confirmed an unsigned copy of the contract had not been provided to the Office of Ombudsman for Long-Term Care or to prospective residents as required. Written Contract R1 and R2's records lacked evidence of an written contract prior to providing assisted living services. R1 and R2 began receiving assisted living services on August 1, 2021. R1 On October 19, 2021, at approximately 7:50 a.m. unlicensed personnel (ULP)-C and ULP-I were observed to assist R1 with morning cares. R1's Service Plan Agreement dated July 15, 2021, noted services included assistance with activities of daily living. On October 20, 2021, at approximately 1:32 p.m. executive director (ED) stated she had sent out a letter dated August 1, 2021, to all residents to come down to her office to sign a new contract. ED stated she also went to the resident council to ask them so come sign the contract, which would be changed effective August 1, 2021.	0 900		

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0 900	Continued From page 39 R2 On October 19, 2021, at approximately 8:45 a.m. R2 sat at a table in the memory care unit's dining room eating breakfast with assistance from a hospice staff. R2's Service Plan Agreement dated March 25, 2021, noted services included assistance with activities of daily living. On October 20, 2021, at approximately 1:55 p.m. BOM and DRS verified R1 and R2's records lacked a signed copy of the contract as required. Designated Representative/R3 R3's written contract dated September 5, 2021, lacked designated representative information. R3's Service Plan Agreement dated September 15, 2021, noted services included assistance with activities of daily living. On October 19, 2021, at 1:50 p.m. R3 was observed seated in his room watching TV. R3 stated he liked living at the facility and received cares, but could not recall what they were. R3 stated he had a call pendant and when he needed something he pushed it and staff would come to help him. R3 said he had a son who was usually called if there were concerns. During a phone interview on October 20, 2021, at 1:30 p.m. the ED stated a few residents had signed new contracts, but most had not. The ED said she could not answer questions about the contracts since she did not have a copy in front of her.	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

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0 900	Continued From page 40 A policy related to the contract was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01460 SS=E	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of four employees (registered nurse (RN)-E and unlicensed personnel (ULP)-D) 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	01460		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01460	Continued From page 41 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on October 18, 2021, at approximately 9:55 a.m. RN-A stated the licensee used a supplemental staffing agency to meet their staffing needs for ULP, and had contracted on-call nurses to cover for 7:00 p.m. to 7:00 a.m. RN-E and ULP-D's records lacked orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. RN-E RN-E had a start date of August 1, 2021, as a contracted nurse to provide on-call services as needed. ULP-D ULP-D worked with a temporary staffing agency contracted by the licensee. On October 18, 2021, at approximately 10:50 a.m. ULP-D was observed in the medication room on the second floor charting. On October 20, 2021, at approximately 8:53 a.m. business office manager (BOM) stated RN-E only takes call for the building from 7:00 p.m. to 7:00 a.m., and was never in the building. On October 20, 2021, at approximately 1:00 p.m. BOM confirmed the contracted staff received no	01460		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

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01460	Continued From page 42 training from the licensee. The licensee's Personnel Records policy dated July 29, 2021, noted a personnel record would be maintained for each contractor providing home care services, which would include a record of home care orientation. The licensee's undated Assisted Living with Memory Care Orientation - All Staff policy noted all assisted living employees must complete orientation to assisted living facility licensing requirements and regulations prior to providing services to residents, including, but not limited to: - an overview of Minnesota's assisted living law; - an introduction and review of the agency policies and procedures related to the provision of assisted living services; - emergency and disaster training; - the assisted living bill of rights; - principles of person-centered planning and service delivery and how they apply to direct support services; - types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and the provider's scope of licensure; - maltreatment of vulnerable adults, and how to report maltreatment; and - complaint process No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01470 SS=F	144G.63 Subd. 2 Content of required orientation	01470		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01470	Continued From page 43 (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must	01470		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

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01470	Continued From page 44 include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of two employees (registered nurse (RN)-A and unlicensed personnel (ULP)-C) 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-A and ULP-C's records lacked orientation to include:	01470		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01470	Continued From page 45 - an overview of Minnesota Statutes, section 144G.08 to 144G.95; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and - a review of the types of assisted living services the employee would be providing and the facility's category of licensure RN-A and ULP-D began providing assisted living services for the licensee on August 1, 2021. On October 19, 2021, at approximately 7:50 a.m. ULP-C was observed providing personal cares to R1 in her apartment. On October 21, 2021, at approximately 9:30 a.m. RN-A and business office manager (BOM) confirmed not all policies had been developed to include the new Assisted Living Licensure requirements, and none of the licensee's employees had received the above required training. The licensee's undated Assisted Living with Memory Care Orientation - All Staff policy noted all assisted living employees must complete orientation to assisted living facility licensing requirements and regulations prior to providing services to residents, including, but not limited to: - an overview of Minnesota's assisted living law; - an introduction and review of the agency	01470		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01470	Continued From page 46 policies and procedures related to the provision of assisted living services; - the assisted living bill of rights; - principles of person-centered planning and service delivery and how they apply to direct support services; and - types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and the provider's scope of licensure No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced	01540		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

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01540	Continued From page 47 by: Based on observation, interview and record review, the licensee failed to ensure staff completed the required amount of dementia care training in the required time frame for three of four employees (registered nurse (RN)-A, RN-E, unlicensed personnel (ULP)-C and ULP-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an Assisted Living with Dementia Care license issued on July 22, 2021. RN-E, ULP-C and ULP-D began providing assisted living services for the licensee on August 1, 2021. RN-E and ULP-D On October 18, 2021, at approximately 10:50 a.m. ULP-D was observed in the medication room on the second floor charting. RN-E and ULP-D's records lacked evidence of any required training related to dementia care. RN-A and ULP-C RN-A and ULP-C's records lacked evidence of the following required training content: - person-centered planning and service delivery;	01540		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01540	Continued From page 48 - understanding cognitive impairment, and behavioral and psychological symptoms of dementia; and - standards of dementia care, including nonpharmacological dementia care practices that are person-centered and evidence informed On October 19, 2021, at approximately 7:50 a.m. ULP-C was observed providing personal cares to R1 in her apartment. ULP-C's record contained evidence of 7.25 hours training, which was less than the required eight (8) hours, and lacked the above required content. RN-A's record contained evidence of a total of 12.25 hours training, but lacked the above required content. On October 21, 2021, at approximately 9:30 a.m. RN-A and business office manager (BOM) confirmed the licensee had no evidence of dementia training for RN-E and ULP-D, and lacked evidence of the above required topics for RN-A and ULP-C. The licensee's Assisted Living with Memory Care Dementia Training policy dated July 29, 2021, noted supervisors of direct-care staff would complete a minimum of 8 hours initial training within 120 working hours of the employment start date, and direct-care employees would complete a minimum of 8 hours initial training on dementia care topics within 80 working hours of the employment start date. In addition, the policy indicated training included, but was not limited to: - person-centered planning and service delivery; - understanding cognitive impairment; - understanding behavioral and psychological	01540		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01540	Continued From page 49 symptoms of dementia; and - standards of dementia care including nonpharmacological dementia care practices that are person-centered and evidence-informed No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01540		
01640 SS=D	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 interview and record review, the	01640		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

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01640	Continued From page 50	01640		

licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for two of four residents (R6 and R7) 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

R6
R6's Service Plan Agreements printed October 19, 2021, lacked a signature or other authentication by the resident or by the facility, documenting agreement on the services to be provided.

On October 19, 2021, at approximately 3:53 p.m. registered nurse (RN)-A confirmed R6 lacked a service plan signed by the resident or the facility.

R7
R7's Service Plan Agreement, printed October 19, 2021, lacked a signature or other authentication by the resident or by the facility, documenting agreement on the services to be provided.

On October 21, 2021, at approximately 8:20 a.m. RN-A stated she was unsure if there was an updated signed service plan. RN-A said R7 had hospice services and received medications from the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

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01640	Continued From page 51 The licensee's Contents of Service Plans policy dated July 28, 2021, noted service plans and any revisions would have a signature or other authentication by the facility and the resident. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640		
01650 SS=C	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned	01650		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

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01650	Continued From page 52 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 two of two residents (R1 and R2) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 and R2's service plans lacked the following required content: - the schedule and methods of monitoring assessments of the resident; and - the methods of monitoring staff providing services R1 On October 19, 2021, at approximately 7:50 a.m., unlicensed personnel (ULP)-C and ULP-I were observed to assist R1 with morning cares. R1's Service Plan Agreement dated July 15, 2021, noted services included assistance with activities of daily living; however, the service plan lacked the above required content. On October 20, 2021, at approximately 2:30 p.m. registered nurse (RN)-H verified the above required content was missing from R1's service	01650		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01650	Continued From page 53 plan, and confirmed the same template was utilized for all residents. R2 On October 19, 2021, at approximately 8:45 a.m. R2 sat at a table in the memory care dining room eating breakfast with assistance from a hospice staff. R2's Service Plan Agreement dated March 25, 2021, noted services included assistance with activities of daily living. On October 20, 2021, at approximately 2:49 p.m. RN-H verified the above required content was missing from R2's service plan, and confirmed the same template was utilized for all residents. The licensee's Contents of Service Plans policy dated July 28, 2021, indicated the service plan would include the schedule and methods of monitoring assessments, and the schedule and methods of monitoring staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01700 SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(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
01700	Continued From page 54	01700		

medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.
(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

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) conducted an individualized assessment prior to providing medication management services to one of two residents (R2), and failed to determine what medication management services would be provided, and how the services would be provided for two of two residents (R2, R3) 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(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
01700	Continued From page 55 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 and R3's records lacked evidence the RN had conducted an assessment to include: - an identification and review of all medications the resident was known to be taking. R2 R2 began receiving services on March 25, 2021, under the comprehensive home care license with diagnoses that included, but were not limited to, dementia without behavioral disturbances, hemiparesis and hemiplegia (paralysis on one side), and adult failure to thrive. On October 19, 2021, at approximately 8:45 a.m. R2 sat at a table in the memory care dining room eating breakfast with assistance from a hospice staff. R2's Service Plan Agreement dated March 25, 2021, noted R2 required assistance with medication administration. R2's prescriber's orders dated September 23, 2021, included but were not limited to, a pain reliever, an antidepressant, and an antianxiety. On October 20, 2021, at approximately 2:44 p.m. registered nurse (RN)-A verified R2's medication management assessment was completed on March 26, 2021, not prior to providing medication management. In addition, RN-A stated she wasn't sure what she had used to identify the	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(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
01700	Continued From page 56 medications the resident was taking to complete the assessment, but confirmed this was not indicated on the assessment. R3 R3's Service Plan Agreement dated September 15, 2021, noted services included medication administration. R3's undated medication list indicated R3 received medications for mood and cardiac diagnoses. On October 19, 2021, at 1:50 p.m. R3 was observed seated in his room watching TV. On October 20, 2021, at 2:30 p.m. RN-A stated she wasn't sure what she had used to identify the medications the resident was taking to complete the assessment, but confirmed this was not indicated on R3's initial assessment. The licensee's Medication, Treatment and Therapy Reminders policy dated July 28, 2021, indicated prior to providing any medication, the RN would conduct a nursing assessment of the resident's functional status and need for medication management services, and would develop an individualized medication management plan based on the resident's needs and preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(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
01730	Continued From page 57 (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(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
01730	Continued From page 58 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 an individualized medication management plan prior to providing medication management services, and with the required content, for two of two residents (R2, R3), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on October 18, 2021, at approximately 9:55 a.m. registered nurse (RN)-A indicated the licensee provided medication management services for the licensee's residents. R2's record lacked a medication management plan to include the following required content: - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. R2 began receiving services on March 25, 2021,	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(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
01730	Continued From page 59	01730		

with diagnoses that included, but were not limited to, dementia without behavioral disturbances, hemiparesis and hemiplegia (paralysis on one side), and adult failure to thrive.

On October 19, 2021, at approximately 8:45 a.m. R2 sat at a table in the memory care dining room eating breakfast with assistance from a hospice staff.

R2's Service Plan Agreement dated March 25, 2021, noted R2 required assistance with medication administration.

R2's prescriber's orders dated September 23, 2021, included but were not limited to, a pain reliever, an antidepressant, and an antianxiety.

R2's record included a Medication Management Plan, dated June 25, 2021.

On October 20, 2021, at approximately 2:44 p.m. registered nurse (RN)-A verified R2's medication management plan was completed three months after R2 was admitted, not prior to providing medication management services as required. RN-A further stated she was not aware that a separate plan was required.

On October 20, 2021, at approximately 2:46 p.m. RN-H verified R2's record lacked a medication management plan with the above required content.

R3

R3's medication management plan, dated September 6, 2021, lacked the required content:
- procedures for staff notifying a registered nurse or appropriate licensed health professional when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(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
01730	Continued From page 60 a problem arises with medication management services. The section on R3's medication management plan indicated "yes" but lacked process information. R3's Service Plan Agreement dated September 15, 2021, noted services included medication administration. R3's undated medication list indicated R3 received medications for mood and cardiac diagnoses. On October 19, 2021, at 1:50 p.m. R3 was observed seated in his room watching TV. During an interview on October 20, 2021, at approximately 2:30 p.m. RN-A said she thought there was a place to document R3's medication management in the initial assessment. The licensee's Development of the Individual Therapy/Treatment Plan policy dated July 28, 2021, indicated an individualized plan would be developed and maintained and must contain procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(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 61	01760		

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 as prescribed for one of three residents (R7) 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:

R7's Service Plan printed on October 19, 2021, noted services included staff assistance with toileting, applying and removing support stockings, dressing, and escorts to meals. The service plan lacked information regarding R7's medication management and administration.

R7's diagnoses included Parkinson's disease,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(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 62 type 2 diabetes, coronary artery disease and chronic atrial fibrillation. R7's medication management plan dated June 25, 2021, and signed by registered nurse (RN)-A indicated R7 received medication management and administration services. R7's medication management plan indicated monitoring supplies and refills of medications would be done by: R7's family, the agency RN or LPN, and R7. Most of R7's medications were obtained from the Veterans Administration Medical Center (VAMC). R7's family were to provide over-the-counter medications. A progress note dated September 1, 2021, at 3:27 p.m. indicated RN-A spoke to a VA nurse and was directed to order R7's medications through his hospice service. A progress note dated October 19, 2021, at 10:56 a.m. indicated RN-A called a pharmacy and hospice to reorder R7's acetylsalicylic acid (ASA). R7's medication sheets dated October 2021, indicated R7 received Aspirin 81 mg chew, take one tablet by mouth daily for heart health. R7's medication sheets indicated R7 did not receive his prescribed ASA on October 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18 and 19, 2021. Documentation of why R7 did not receive his daily dose of ASA for each of the 12 days was: "No supply." On October 19, 2021, at approximately 8:29 a.m. ULP-I prepared R7's medication (Senokot 8.6 mg tablet, 2 tabs by mouth once daily) and administered the medication to R7 in his room. ULP-I stated the facility was out of R7's ASA and staff needed to tell RN-A about any medication issues since she ordered the medications, and	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(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 63 orders usually arrived on Wednesdays. On October 21, 2021, at approximately 8:20 a.m. RN-A said she did not recall anyone telling her R7 was out of ASA. RN-A stated her expectation would be that staff notify her 2 weeks before they run out of resident medications. Staff can notify her in person or by text. RN-A did not think any texts from staff were saved. The licensee's Requesting and Receiving Medication Prescriptions and Refills policy dated July 28, 2021, indicated if the facility is managing a resident's prescription refills and prescriptions, the nurse will develop a system to notify the nurse and or the resident's representative when a prescription must be refilled so the resdient's prescription does not run out. The licensee's Renewal of Medication, Treatment or Therapy Prescriptions and Orders policy dated August 23, 2021, indicated the nurse or licensed health professional will contact the prescriber to notify that the order or prescription needs to be renewed. The nurse or licensed health professional will document all actions and communications regarding orders or prescriptions that need to be renewed. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01760		
01770 SS=E	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(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
01770	Continued From page 64 administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R5 and R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on October 18, 2021, at approximately 9:55 a.m. registered nurse (RN)-A confirmed the licensee provided medication setup for two residents. R5 and R6's records lacked documentation by the licensed nurse at the time of medication setup to include the following required documentation content: - dates of medication setup; - the name of the medication; - quantity of dose; - times to be administered; - route of administration; and - name of the person completing medication	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(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
01770	Continued From page 65 setup R5 R5's Service Plan Agreement dated May 12, 2021, indicated the client received services including, but not limited to, medication reminders and setup. R5's prescriber orders dated September 9, 2021, included, but were not limited to, one vitamin supplement and one diuretic (to increase the excretion of water from the body). R6 R6's unsigned and undated Service Plan Agreement indicated the client received medication setup. R6's prescriber orders dated October 13, 2021, included, but were not limited to, one pain reliever, and two vitamin supplements. On October 19, 2021, at approximately 2:00 p.m. RN-A confirmed medication setup was not documented for either of the two residents receiving this service to include the above required content. The licensee's Medication Administration System - Dosage Box Set-up policy dated August 23, 2021, noted when the nurse had completed the medication setup in the dosage box, the nurse would document each individual medication that had been setup on the medication administration record or other section of the resident's legal medical record. No further information was provided.	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(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
01770	Continued From page 66 TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a current written or electronically recorded prescription was obtained for all medications the provider had managed for the one of three residents (R7) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The findings include: R7's Service Plan, unsigned and printed on October 19, 2021, noted services included staff assistance with toileting, applying and removing support stockings, dressing, and escorts to meals. The service plan lacked information regarding R7's medication management and	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

(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
01820	Continued From page 67 administration. R7's diagnoses included Parkinson's disease, type 2 diabetes, coronary artery disease and chronic atrial fibrillation. R7's medication management plan dated June 25, 2021, and signed by registered nurse (RN)-A, indicated R7 received medication management and administration services. R7's medication management plan indicated monitoring supplies and refills of medications would be done by: R7's family, the agency RN or LPN, and R7. Most of R7's medications were obtained from the Veterans Administration Medical Center (VAMC). R7's family were to provide over-the-counter medications. R7's medication sheets for October 2021, indicated R7 had: metformin HCl (diabetes) 500 milligram (mg) tabs-one tablet daily by mouth twice daily with food for diabetes; acetaminophen (pain reliever) 325 mg tabs-two tabs by mouth four times daily as needed for pain; aspirin 81 mg chew-take one tab by mouth daily for heart health; caridopa-levidopa (Parkinson's disease) 25-100 mg TDBP two tabs by mouth at 8 am, 12 pm, 4 pm and 8 pm; eplerenone 25 mg tablet-take 1/2 tab by mouth once daily for edema; magic butt paste-apply one gram to affected area 3-4 times daily for skin irritation/pain; sertraline HCl 100 mg tabs-take one half tab by mouth every day with food for depression; Sotalol HCl 80 mg tabs one tab by mouth twice per day for heart disease, Senokot (laxative) tab 8.6 mg tab-take 2 tabs by mouth once daily. R7's medication sheets dated October 2021, indicated R7 did not receive his prescribed aspirin	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37H AVENUE NORTH SAINT CLOUD, MN 56303

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01820	Continued From page 68 (ASA) on October 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18 and 19, 2021. Staff documented "No supply" for each of the 12 days R7 did not receive his ASA. A progress note dated September 1, 2021, at 3:27 p.m. indicated RN-A spoke to a VA nurse and was directed to order R7's medications through his hospice service. A fax dated October 6, 2021, sent to R7's pharmacy by another nurse requested ASA for R7. RN-A noted on the fax sheet that hospice was called and had the order on October 7, 2021. A progress note dated October 19, 2021, at 10:56 a.m. indicated RN-A called a pharmacy and hospice to reorder R7's acetylsalicylic acid (ASA). On October 19, 2021, at approximately 8:29 a.m. ULP-I prepared R7's medication (Senokot 8.6 mg tablet-2 tabs by mouth once daily) and administered the medication to R7 in his room. ULP-I stated the facility was out of R7's ASA and staff need to tell RN-A about any medication issues since she ordered the medications, and orders usually arrived on Wednesdays. On October 21, 2021, at approximately 8:20 a.m. RN-A said she did not recall anyone telling her R7 was out of ASA. RN-A stated her expectation would be that staff notify her 2 weeks before they run out of a resident's medications. Staff can notify her in person or by text. RN-A did not think staff texts were saved. RN-A stated R7 had hospice services and most of his medications came from the Veterans Administration Medical Center (VAMC) so it was "tricky" getting written or electronically signed prescriptions or medication lists from the VAMC.	01820		

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	34875	A. BUILDING: _____ B. WING _____	10/21/2021

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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
01820	Continued From page 69 On October 21, 2021, at approximately 11:45 a.m. RN-A verified there were no signed prescriptions for R7. RN-A said she has tried to get the information from the VAMC, but has not been successful. The licensee's Resident Records policy dated July 28, 2021, indicated the resdient record will contain health information, if applicable to services received, including orders or prescriptions for medications, treatments or therapies the agency will manage. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01820		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber	01930		

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01930	Continued From page 70 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). The findings include: During the entrance conference on October 18, 2021, at approximately 9:55 a.m. RN-A confirmed the licensee provided treatment management services. A request was made to review the licensee's policies and procedures. The provided policies and procedures failed to address the following: - educating with residents about treatments or therapies they are receiving; and - communicating with the prescriber On October 20, 2021, at approximately 3:25 p.m. RN-H stated he would look for the above policies; however, they were not provided. No further information was provided.	01930		

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01930	Continued From page 71 TIME PERIOD FOR CORRECTION: Seven (7) days	01930		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the proper documentation that a hazard vulnerability or safety risk assessment had been performed on and around the property. This had the potential to affect all residents, visitors and staff. 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:	02040		

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02040	Continued From page 72 On October 18, 2021, at approximately 11:25 a.m. review of facility records provided no evidence of complete hazard vulnerability assessment. This is required per statute and could result in harm to residents, staff, and visitors if not completed. On October 18, 2021, at approximately 11:45 a.m. maintenance director acknowledged the facility had not fully developed the required hazard vulnerability assessment. Global issues such as fire, gas leak, epidemic, and shooter had been identified. Mitigation procedures had not been developed. Local hazards that are site, building, and population specific had not been developed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;	02110		

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02110	Continued From page 73 (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed or implemented, and provided to each resident and/or the residents legal and designated representative at the time of move-in. This had the potential to affect all dementia care 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	02110		

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02110	Continued From page 74 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked evidence the following required policies and procedures related to the dementia care had been developed: - philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - description of life enrichment programs and how activities are implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; and - transportation coordination and assistance to and from outside medical appointments In addition to the above policies, the following policies were not provided to the residents and the residents' legal and designated representative at the time of move-in: - staff training specific to dementia care; and - safekeeping of residents' possessions	02110		

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02110	Continued From page 75 On October 20, 2021, at approximately 3:35 p.m. registered nurse (RN)-H confirmed the licensee lacked the above required policies, and verified none had been provided to the resident or the residents' legal and designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as	02170		

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02170	Continued From page 76 entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions, and failed to develop an individualized activity plan based on the evaluation, for one of one resident (R2) who resided in the secured memory care unit, with record review. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility had an assisted living with dementia care license, effective August 1, 2021. R2's diagnoses included, but were not limited to, vascular dementia (memory disorder), adult failure to thrive, and hemiplegia and hemiparesis (paralysis of one side of the body).	02170		

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02170	Continued From page 77 On October 20, 2021, at approximately 3:50 p.m. the director of resident services (DRS) stated she met with all residents to assess their interests, hobbies, and food likes and dislikes. DRS shared a Resident Lifestyle and Leisure Interests document that she stated she used when she met with the residents. The document lacked evaluation of the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions On October 20, 2021, at approximately 3:55 p.m. DRS indicated she was unaware of the requirement to evaluate residents with dementia for activities and to develop an individualized activity plan. A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02240 SS=E	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can	02240		

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02240	Continued From page 78 understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by:	02240		

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02240	Continued From page 79 Based on observation, interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided and a written acknowledgement was received for two of three residents (R1 and R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 and R2's records lacked evidence of receiving the current bill of rights, and a written acknowledgement. R1 and R2 began receiving assisted living services on August 1,2021. R1 On October 19, 2021, at approximately 7:50 a.m. unlicensed personnel (ULP)-C and ULP-I were observed to assist R1 with morning cares. R1's Service Plan Agreement dated July 15, 2021, noted services included assistance with activities of daily living. R2 On October 19, 2021, at approximately 8:45 a.m. R2 sat at a table in the memory care dining room	02240		

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02240	Continued From page 80 eating breakfast with assistance from a hospice staff. R2's Service Plan Agreement dated March 25, 2021, noted services included assistance with activities of daily living. On October 20, 2021, at approximately 2:30 p.m. registered nurse (RN)-H confirmed R1 and R2 had not received the current bill of rights. In addition, RN-H stated any residents who had not received a new signed contract had not received the current bill of rights. The licensee's Resident Records policy dated July 28, 2021, noted the resident record would contain documentation the resident had received and reviewed the assisted living bill of rights and documentation the facility staff had reviewed the bill of rights with the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced	02260		

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02260	Continued From page 81 by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had an Assisted Living with Dementia Care license, issued on July 22, 2021. During the entrance conference on October 18, 2021, at approximately 9:55 a.m. registered nurse (RN)-A and business office manager (BOM) verified the licensee had a locked dementia care unit. A copy of the dementia training disclosure was requested. The licensee's Memory Care Disclosure dated January 4, 2019, noted staff training would include comprehensive training related to dementia and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, and communication skills. The disclosure lacked the following required content: - person-centered planning and service delivery; - understanding cognitive impairment, and	02260		

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02260	Continued From page 82 behavioral and psychological symptoms of dementia; and - standards of dementia care, including nonpharmacological dementia care practices that are person-centered and evidence informed The licensee's Assisted Living with Memory Care Dementia Training policy dated July 29, 2021, lacked information on a disclosure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02260		

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

Type: Full
Date: *10/18/21*
Time: 10:45:10
Report: 7930211173

Food and Beverage Establishment Inspection Report

Location:
Talamore Senior Living
215 37h Avenue North
St Cloud, MN56303
Stearns County, 73

Establishment Info:
ID #: 0038899
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202275058
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.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

PROVIDE A WATERPROOF THERMOMETER OR THERMOLABELS LIKE STATED ABOVE TO MONITOR THE FINAL RINSE CYCLE IN THE DISHWASHER.

Comply By: 11/01/21

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

FOR QUATERNARY AMMONIA SANITIZER AT THE THREE COMPARTMENT SINK AND SANITIZER BUCKETS.

Comply By: 11/01/21

5-500 Refuse and Recyclables

5-501.17

MN Rule 4626.1260 Provide covered receptacles in the toilet room for sanitary napkins or diapers.

PROVIDE COVERED WASTE RECEPTACLES IN BOTH STAFF RESTROOMS LIKE STATED ABOVE.

Comply By: 10/25/21

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET--WAIT STATION
Violation Issued: No

Hot Water: = at 163.4 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Prep Cooler
Temperature: 37 Degrees Fahrenheit - Location: HAM
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: POTATO SOUP--UPRIGHT TWO DOOR COOLER NEAR WALK-IN
Violation Issued: No

Process/Item: Re-Heating
Temperature: 166 Degrees Fahrenheit - Location: MASHED POTATOES--STEAM TABLE
Violation Issued: No

Process/Item: Re-Heating
Temperature: 172 Degrees Fahrenheit - Location: TURKEY--STEAM TABLE
Violation Issued: No

Process/Item: Steam Table
Temperature: 180 Degrees Fahrenheit - Location: CARROTS
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 36 Degrees Fahrenheit - Location: DICED WATERMELON
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: AMBIENT TEMP--MEMORY CARE SERVING KITCHEN
Violation Issued: No

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

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7930211173 of 10/18/21.

Certified Food Protection Manager: Linda J. Stauffacher

Certification Number: FM89574 Expires: 06/20/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Tracy Hennen

Signed: _____
Inspector ID #7930

651-201-4500
health.foodlodging@state.mn.us

Report #: 7930211173

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	0	Date	10/18/21
No. of Repeat RF/PHI Categories Out	0	Time In	10:45:10
Legal Authority MN Rules Chapter 4626		Time Out	

Talamore Senior Living	Address: 215 37h Avenue North	City/State: St Cloud, MN	Zip Code: 56303	Telephone: 3202275058

License/Permit #: 0038899	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

					COS	R
Safe Food and Water						
30	(IN)	OUT	N/A	Pasteurized eggs used where required		
31				Water & ice obtained from an approved source		
32	IN	OUT	(N/A)	Variance obtained for specialized processing methods		
Food Temperature Control						
33				Proper cooling methods used; adequate equipment for temperature control		
34	(IN)	OUT	N/A N/O	Plant food properly cooked for hot holding		
35	IN	OUT	N/A (N/O)	Approved thawing methods used		
36				Thermometers provided & accurate		
Food Identification						
37				Food properly labled; original container		
Prevention of Food Contamination						
38				Insects, rodents, & animals not present		
39				Contamination prevented during food prep, storage & display		
40				Personal cleanliness		
41				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	X	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	X	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:** 10/18/21

Inspector (Signature)