Electronically Delivered

December 13, 2024

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

RE: Project Number(s) SL34875016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 8, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH 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.

STATE CORRECTION ORDERS

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

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 may be 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.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34875	A. BUILDING: _____ B. WING _____	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAMORE SENIOR LIVING	215 37TH 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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34875016-0 On November 4, 2024, through November 7, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 140 resident(s); 95 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control related to gloving and hand hygiene for two of two unlicensed personnel ((ULP)-B, ULP-L) as well as disinfecting shared equipment. 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: Hand Hygiene ULP-B ULP-B was hired February 16, 2023, to provide	0 510		

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0 510	Continued From page 2 direct cares and services to residents. On November 5, 2024, at 9:35 a.m., surveyor observed ULP-B administering medication to R7. ULP-B logged into charting system, unlocked cart, removed medications, completed rights of administration and dispensed medications from pill cards into medication cup, locked medication cart and computer screen, knocked on resident door, introduced self and purpose for visit, offered cup of water, administered medications, remained at chair-side until resident safely swallowed all medications, returned to med cart to log into charting system, click 'administer' on medications, and select next resident. Without performing hand hygiene, ULP-B opened R5's chart, completed rights of administration for all oral medications, and Humalog (fast acting insulin for diabetes). Pills were dispensed into plastic med cup. Humalog insulin pen cap was removed and the tip of the pen was cleaned with alcohol wipe, ULP-B attached the safety needle to the pen, dialed up two units of insulin and wasted, and then dialed up 30 units as prescribed by provider. ULP-B then completed hand hygiene and applied clean gloves, gathered supplies and entered R5's room. ULP-B administered medications to R5 and then obtained R5's blood glucose. ULP-B removed gloves without performing hand hygiene, and returned to the medication cart to complete documentation. Without performing hand hygiene, ULP-B entered medication room to stock supplies. ULP-L ULP-L was hired May 9, 2022, to provide direct cares and services to residents. On November 6, 2024, at 7:35 a.m., surveyor observed ULP-L provide care for R8. ULP-L	0 510		

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0 510	Continued From page 3 knocked on R8's door, introduced herself and reason for the visit, donned gloves without performing hand hygiene, assisted R8 with donning compression stockings followed by socks, a clean pull-up brief, jeans, and shoes. R8 then stood at the bedside and ULP-L removed the soiled brief. R8 then completed lower body dressing by raising their brief, pants, and securing their belt. R8 then sat back down on the bedside while ULP-L disposed of the soiled brief and doffed gloves without performing hand hygiene. ULP-L then provided R8 with stand-by assist ambulation to the dining room for breakfast. Without performing hand hygiene, ULP-L then entered R9's room and assisted R9 with transferring from their chair to the toilet. ULP-L donned gloves and assisted R9 by removing their soiled brief, applying a new brief, pants, and slippers. ULP-L then assisted R9 with peri-cares, raised R9's brief and pants, and assisted R9 to sit in their power wheelchair. ULP-L then removed gloves and without hand hygiene assisted R9 with upper body dressing. When ULP-L completed cares, they exited R9's room to attend to other tasks. Disinfecting Shared Equipment On November 5, 2024, from 9:45 a.m. until 9:55 a.m., ULP-B used a facility glucose meter (equipment used to measure blood sugar) to obtain R5's blood sugar. After obtaining R5's blood sugar, ULP-B returned the facility glucose meter to the medication cart for storage without sanitizing per licensee's policy. On November 5, 2024, at 10:15 a.m., ULP-B indicated that the facility glucose meter gets wiped down with a sanitizing wipe at the beginning of each day.	0 510		

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0 510	Continued From page 4 The Centers for Disease Control and Prevention (CDC) Hand Hygiene in Health Care Settings Healthcare Providers guidance dated January 30, 2020, directed health care workers to wash their hands immediately before touching a patient [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled. The licensee's Hand Hygiene policy dated July 23, 2021, indicated "When Hands Should be Washed. Hand washing shall be performed between client cares and whenever direct physical contact with a client takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: 1 Before and after direct contact with a client 2 If moving from a contaminated-body site to a clean-body site during client care 3 After contact with environmental surfaces or equipment in the immediate vicinity of the client 4 After removing gloves or gowns 5 Before eating and after using a restroom." The licensee's Disinfecting Reusable Equipment and Environmental Surfaces policy dated December 29, 2022, indicated, "After using reusable equipment, (such as toenail and nail clippers, O2 monitors, vitals equipment,), the equipment must be cleaned and returned to the place that it is stored. Glucometers must be cleaned after each use following the manufacturer's instructions." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 680	Continued From page 5	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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 interview and record review, the licensee failed to have a written emergency preparedness (EP) plan available to staff for utilization during an emergency. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 6 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's EP plan lacked the following required contents: -establish a policy and procedure that addresses the use of volunteers, including the process/role for integration; -communication plan must include all the names/contact information for residents' physicians; -communication plan must include contact information for the Minnesota Office of Ombudsman for long term care (LTC) and other sources of assistance; and -must conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP and must include the following: -participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise or if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise, -conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise or mock disaster drill or table-top exercise, -analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events and revise plan as needed.	0 680		

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0 680	Continued From page 7 On November 5, 2024, at 9:30 a.m., the licensed assisted living director (LALD)-C stated, "We noticed that we were missing some drills so you will see some drills for October, but we literally just did those this week." Surveyor asked if this week meant the day before (November 4, 2024) and LALD-C stated, "Correct we did them yesterday (after the start of this survey), we noticed they were missing so we wanted to quick get them done." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview, observation, and record	01290		

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01290	Continued From page 8 review, the licensee failed to ensure a background study was conducted and/or affiliated with the assisted living with dementia care license for five of 71 employees, unlicensed personnel (ULP)-H, ULP-J, ULP-K, director of maintenance (DM)-E, and clinical assistant/unlicensed personnel (CA/ULP)-I. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 5, 2024, at 12:30 p.m., surveyor received the licensee's Netstudy 2.0 affiliation report. ULP-H ULP-H began employment on November 9, 2020, under the former comprehensive license and started providing assisted living services August 1, 2021. ULP-H's employee record contained a background study dated November 4, 2020. ULP-H's record lacked evidence the licensee submitted a background study for ULP-H under the current assisted living with dementia care license and affiliated to the current HFID number. ULP-J ULP-J began employment on June 9, 2020, under the former comprehensive license and	01290		

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01290	Continued From page 9 started providing assisted living services August 1, 2021. ULP-J's employee record contained a background study dated June 9, 2020. ULP-J's record lacked evidence the licensee submitted a background study for ULP-J under the current assisted living with dementia care license and affiliated to the current HFID number. ULP-K ULP-K began employment on February 6, 2024 and started providing assisted living services. ULP-K's employee record lacked evidence the licensee submitted a background study under the current assisted living with dementia care license and affiliated to the current HFID number. DM-E DM-E began employment on January 6, 2006, under the former comprehensive license and started providing director of maintenance services August 1, 2021. On November 5, 2024, at 10:30 a.m., DM-E was observed to facilitate a building tour for the Minnesota Department of Health engineer on survey. DM-E's employee record contained a background study dated October 27, 2020. DM-E's record lacked evidence the licensee submitted a background study for DM-E under the current assisted living with dementia care license and affiliated to the current HFID number. CA/ULP-I CA/ULP-I began employment on October 5, 2020, under the former comprehensive license	01290		

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01290	Continued From page 10 and started providing scheduling and assisted living services August 1, 2021. On November 5, 2024, at 3:20 p.m., surveyor observed CA/ULP-I working on the nursing schedule for the licensee. CA/ULP-I's employee record contained a background study dated October 26, 2020. CA/ULP-I's record lacked evidence the licensee submitted a background study for CA/ULP-I under the current assisted living with dementia care license and affiliated to the current HFID number. On November 5, 2024, at 12:52 p.m., business office manager (BOM)-G stated "[the above employees] were from before I started working here so they last person in this role would have ran their background studies. I wonder if they knew they needed to be reran in 2021." BOM-G indicated that all of the above employees worked at the licensee long enough that they would be working on the floor unsupervised with residents. On November 5, 2024, at 12:58 p.m., BOM-G stated, "I am currently auditing my files, and [ULP-K] was on my list because I couldn't find one for him either. So I started going through all my employee files." On November 5, 2024, at 2:49 p.m., LALD-C indicated he would look for a background study policy as he was unaware if they had one. LALD-C stated, "obviously they should have been run but no I can't tell you why they were not run. I was not here when they were hired but going forward everyone should have a background study."	01290		

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01290	Continued From page 11 The licensee's Screening of Home Care Job Applicants policy dated January 28, 2020, indicated, "No new employee will have unsupervised direct contact with clients until all required screenings have been satisfactorily completed and any applicable licenses, registrations, or certifications have been verified." The licensee was unable to provide any other policy addressing background studies for the assisted living license. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
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 by:	01540		

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01540	Continued From page 12 Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-M) completed the required amount of dementia care training in the required time frame. 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: ULP-M was hired September 17, 2024, to provide direct cares and assisted living services to residents. ULP-M's employee file contained an All Staff Training and Competency Checklist - New Employee Orientation form, dated September 23, 2024, that indicated seven total dementia training hours were completed, but lacked documentation for eight training hours on dementia. On November 7, 2024, at 12:55 p.m., clinical nurse supervisor (CNS)-D stated, "[ULP-M] doesn't have the eight hours because she took the class. The dementia class is the same for everyone, so it would only be seven hours for all that took the class." The licensee's Assisted Living with Memory Care Dementia Training policy, dated July 29, 2021, indicated, "Direct-care employees will 1. complete a minimum of eight hours of initial training on	01540		

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01540	Continued From page 13 dementia care topics 2. initial training will be completed within 80 working hours of the employment start date." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (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	01730		

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01730	Continued From page 14 (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for four of four residents (R3, R4, R5, and R6). 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: R3 R3 was admitted to the licensee and began receiving assisted living services on January 31, 2024. R3's diagnoses included congestive heart failure, depression, type 2 diabetes mellitus, and	01730		

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01730	Continued From page 15 Alzheimer's. R3's Service Plan Agreement, signed and dated March 21, 2024, included bathing, meals, dressing, grooming, monthly vital signs, housekeeping, linens, laundry, medication administration, toileting, transfer assist of one, safety checks, and activity escorts. R4 R4 was admitted to the licensee and began receiving assisted living services on December 29, 2022. R4's diagnoses included dementia, anxiety disorder, coronary artery disease, type 2 diabetes mellitus, gastroesophageal reflux disease, hearing loss, and hypertension. R4's Service Plan Agreement, signed and dated November 4, 2024, included bathing, meals, dressing, grooming, monthly vital signs, housekeeping, linens, laundry, medication administration, and behavior management. R5 R5 was admitted to the licensee and began receiving assisted living services on June 13, 2022. R5's diagnoses included type 2 diabetes mellitus, dementia, hypertension, polyarthritis, and cerebral infarction. R5's Service Plan Agreement, signed and dated October 1, 2024, indicated R5's services included monthly vital signs, housekeeping, linens, laundry, medication administration, behavior management, and blood glucose monitoring.	01730		

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01730	Continued From page 16 R6 R6 was admitted to the licensee and began receiving assisted living services on April 2, 2024. R6's diagnoses included unspecified disorder of eyelid, repeated falls, chondrocalcinosis, cardiomyopathies, duodenal ulcer (unspecified acute or chronic), acute post hemorrhagic anemia, gross hematuria, and dyslipidemia. R6's Service Plan Agreement, signed and dated August 1, 2024, indicated R6's services included bathing, dressing, meals, monthly vital signs, housekeeping, linen, laundry, medication administration, ambulation with assist of one, transfers with assist of one, safety checks, and toileting with assist of one. R3, R4, R5, and R6's Master Assessment Section 6. Medication Management lacked identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. On November 6, 2024, at 10:50 a.m., clinical nurse supervisor (CNS)-D stated, "One of the nurses orders the medications. Honestly, I think it is just a missing question and is missing from all of the assessments. The regional nurses built the assessment." The licensee's Storage of Medications policy dated December 29, 2022, indicated, "The RN will establish a system that addresses the storage and handling of medications, including: a. How medications will be received and secured when delivered by the pharmacy b. Where medications will be stored c. How medications will be secured if in the resident's private living space or if centrally stored	01730		

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01730	Continued From page 17 d. Who is authorized to access the medications e. How refills and prescription renewals will be monitored." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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 interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of four residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6 admitted to the licensee and began receiving services on April 4, 2024.	01820		

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01820	Continued From page 18 R6 had diagnoses to include unspecified disorder of eyelid, repeated falls, Chondrocalcinosis (arthritis causing calcium deposits in joints), cardiomyopathies (disease of heart muscle), duodenal ulcer (ulcer in the small intestine), acute post hemorrhagic anemia (large blood loss), gross hematuria (blood in urine), dyslipidemia (high fat content in blood). R6's signed service plan dated August 1, 2024, indicated R6 received assistance with bathing, meals, dressing, vital sign monitoring, housekeeping, linen laundry, personal laundry, medication management, ambulation assistance, transfer assistance, and toileting assistance. R6's Medication Administration Record (MAR) dated November 1, 2024, through November 30, 2024, listed the medications, times to administer, and staff initials to indicate the medications had been administered. The MAR indicated that R6 received magnesium oxide 400 milligrams (mg) (mineral supplement to treat low magnesium levels in the blood) at 9:00 a.m. and 8:00 p.m., gabapentin 100 mg (pain management) at bedtime if needed, and oxycodone 5 mg (pain management) every six hours as needed. R6's records lacked signed orders for magnesium oxide 400 mg gabapentin 100 mg, and oxycodone 5 mg. On November 7, 2024, at 9:00 a.m., CNS-D indicated that signed orders for the above medications were not in resident record and she would contact the pharmacy to request copies of each prescription be faxed to the licensee. The licensee's Renewal of Medication, Treatment or Therapy Prescriptions and Orders policy dated	01820		

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01820	Continued From page 19 August 23, 2021, indicated, "A medication prescription or a treatment or therapy order must current and must be renewed at least every twelve (12) months." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescription medications were stored according to the manufacturer's directions for one of one resident (R12). 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 the residents). The findings include: On November 6, 2024, at 7:15 a.m., surveyor	01880		

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01880	Continued From page 20 observed the medication refrigerator to contain: - 11 facility stock Bisacodyl rectal suppositories; and - R12 prescription Bisacodyl rectal suppositories. Licensee's document titled Service Received printed November 6, 2024, indicated the medication refrigerator was kept between 33 degrees Fahrenheit (F) and 50 degrees F from October 1, 2024, through November 4, 2024. The manufacturer instructions located on R12 Bisacodyl prescription indicated medication to be stored at a temperature between 68 degrees F and 77 degrees F. On November 6, 2024, at 1:00 p.m., CNS-D indicated licensed staff completes task daily on evening shift. Specific range instructions are listed in the computer charting software for 36 to 46 degrees Fahrenheit (F), and staff must notify maintenance or CNS-D if temperatures are out of range. The licensee's Storage of Medication policy dated December 29, 2022, indicated "When secured storage of the medications is necessary, the RN will identify based upon assessment where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 21 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of nine resident (R3) with hospital-style bed rails and consumer bed rails and assistive devices. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 admitted to the licensee and began receiving services on January 31, 2024. R3 had diagnoses to include Type 2 diabetes, hypertension, schizoaffective disorder, and generalized weakness. R3's signed Care Plan dated March 21, 2024, indicated R3 received assistance with bathing, dressing, grooming, mobility assistance, meals, medication administration, monthly vital signs, toileting, laundry, and housekeeping.	02310		

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02310	Continued From page 22 On November 6, 2024, at 1:33 p.m. surveyor observed R3's bed had one hospital-style bed rail located at the head of the hospital bed on the right side and firmly attached to the bed. R3's bed also had a consumer style bed rail at the top left side of the bed. The consumer bedrail was strapped around the frame of the bed, however it was not secured as it was eaily moveable. On November 7, 2024, at 10:20 a.m., unlicensed personnel (ULP)-B stated, "She really uses the bedrails the most when getting out of bed, She is able to use the arm of the wheelchair and the bedrail to help her get out of the bed." R3's record lacked a bedrail assessment to include; - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; and -evidence the licensee measured the bed rail zones of entrapment. On November 7, 2024, at 9:22 a.m., clinical nurse supervisor (CNS)-D stated, "You are correct [the electronic charting system] was not triggered to	02310		

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02310	Continued From page 23 do [a bed rail assessment]. So, where it says assistive equipment you have to click yes or no and it wasn't clicked so it didn't trigger it to do." The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls.	02310		

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02310	Continued From page 24 This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Assessing the Safety of Side Rails policy, dated October 25, 2023, indicated, "1. When the RN is notified that a resident has a side rail, the RN will assess and evaluate what the resident ' s needs are and assess to determine if the resident can safely utilize the side rail/equipment and determine whether the side rail/equipment meets the FDA standards and/or installed per manufacturer guidelines.	02310		

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TALAMORE SENIOR LIVING	215 37TH 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
02310	Continued From page 25 2. The RN will educate the resident, the resident ' s representative and/or the resident ' s family regarding side rail safety and risks including potential death due to falls, injuries, entrapment, and/or asphyxiation. 3. If the RN determines that the side rails are not a safe device for the resident, or that the resident ' s side rail does not meet the FDA or most current safety guidelines, the RN will recommend that the side rail should be removed or replaced with an alternative device. If the RN determines that the side rails are not a safe device for the resident, the RN will provide options to residents and/or designated representative. The RN will document these recommended options and the response from the resident and/or resident ' s designated representative the RN ' s recommendations." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

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

Type: Full
Date: *11/04/24*
Time: 10:30:20
Report: 1046241263

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.

No NEW orders were issued during this inspection.

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

FOOD IS CATERED IN FROM UNIDINE, PLATED IN THE KITCHEN (MEMORY CARE), AND BROUGHT DIRECTLY TO THE TABLES FOR THE RESIDENTS IN THE ASSISTED LIVING. DISHES ARE WASHED IN THE KITCHEN.

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 1046241263 of 11/04/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Nicole Larrison
Public Health Sanitarian
St. Cloud
320-472-0042
nicole.larrison@state.mn.us