DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 21, 2022

Administrator
Oasis Care Home, LLC
514 Britz Drive
Luverne, MN 56156

RE: Project Number(s) SL33288015

Dear Administrator:

On September 20, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the August 4, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, RN, BSN
Interim HFE Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-5175 | Mobile: 651-508-2791| Fax: 218-332-5196

PMB

Electronically Delivered

August 23, 2022

Administrator
Oasis Care Home LLC
514 Britz Drive
Luverne, MN 56156

RE: Project Number(s) SL33288015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 4, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), 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

St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00

The total amount you are assessed is $3,500.00. 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 by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

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 be 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 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 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
	33288	A. BUILDING: _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS CARE HOME LLC	514 BRITZ DRIVE LUVERNE, MN 56156

(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(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: SL33288015 On August 2, 2022, through August 4, 2022, 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 three (3) residents, all of whom received services under the provider's Assisted Living 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 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	0 250		

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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 oversaw 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 entrance conference on August 2, 2022, at approximately 10:30 a.m., licensed assisted living director (LALD)-D stated she reviewed the current assisted living regulations on-line and confirmed the licensee had developed and implemented current and up to date policies and procedures.	0 250		

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0 250	Continued From page 3 The licensee failed to ensure the following policies and procedures were in place and kept current: - 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; - medication and treatment management; and - supervision of unlicensed personnel performing delegated tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 430 SS=C	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	0 430		

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0 430	Continued From page 4 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 interview and record review, the licensee failed to provide the licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to one of one resident (R1) with record 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 the potential to affect a large portion or all the residents). The findings include: R1 was admitted on October 1, 2020. R1's record lacked documentation R1 received the licensee's UDALSA. On August 2, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-D acknowledged no documentation of receipt of licensee's UDALSA was included in R1's record. LALD-D stated the licensee was working on completing a UDALSA but at the time had not finished the document. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		

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0 450	Continued From page 5	0 450		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current bill of rights (BOR) for assisted living to two of two residents (R1, 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 the residents). The findings include: R1 was admitted on October 1, 2020. R1's record included an Acknowledgements form dated October 1, 2020, which indicated R1	0 450		

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0 450	Continued From page 6 received the BOR upon admission to facility. A copy of the BOR with a revised date of 2019 was included in R1's record. R2 was admitted on November 18, 2021. R2's record included an Acknowledgements form dated November 18, 2021, which indicated R2 received the BOR upon admission to facility. A copy of the BOR with a revised date of 2019 was included in R2's record. On August 3, 2022, at approximately 1:00 p.m., licensed assisted living director (LALD)-D stated all residents received a copy of the BOR upon admission and LALD-D could only find the 2019 BOR online to give to residents. LALD-D stated she did not know how to obtain the most updated BOR. The licensee's undated Bill of Rights policy indicated the licensee would ensure each client received a copy of the Home Care Bill of Rights that is current. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable	0 470		

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0 470	Continued From page 7 unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop or implement a staffing plan to determine its staffing level. This had the potential to affect all three residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	0 470		

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0 470	Continued From page 8 The licensee held an assisted living license, effective August 1, 2022. The licensee was licensed for a resident capacity of five residents and had a current census of three residents. During the entrance conference on August 2, 2022, at approximately 10:30 a.m., licensed assisted living director (LALD)-D explained how the licensee staffed its building. LALD-D questioned what a staffing plan was. The surveyor explained what a staffing plan was, and LALD-D reiterated the licensee had not developed a staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the 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 9 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all three residents in the Assisted Living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated August 2, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=D	144G.41 Subd 1. (13) (i) (A) and (C) 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)	0 485		

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0 485	Continued From page 10 guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a menu was prepared and provided to residents a week in advance. This had the potential to affect all residents. 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 the residents). The findings include: On August 2, 2022, at approximately 10:30 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated meals are provided and prepared by the licensee and the licensee does have a menu available to the residents to view.	0 485		

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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
0 485	Continued From page 11 On August 2, 2022, at approximately 11:30 a.m., during a facility tour, the surveyor did not observe a menu posted in a common area. The surveyor asked unlicensed personnel (ULP)-B where the licensee's menu was located. ULP-B proceeded to look through kitchen drawers where she obtained an undated monthly calendar showing three meals on each calendar day. During an interview on August 3, 2022, at approximately 11:15 a.m., LALD-D stated she was not aware the menu had not been posted for the residents to view. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (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	0 510		

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	33288	A. BUILDING: _____ B. WING _____	08/04/2022

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0 510	Continued From page 12 review, the licensee failed to establish and maintain infection control policies and procedures that complied with accepted health care, medical, and nursing standards for infection control related to the COVID-19 pandemic when the licensee failed to ensure visitors, employees, and residents were screened for COVID-19 with temperature checks and screening questions and failed to develop policies and procedures to guide decision making related to COVID-19 pandemic. 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 all four residents). The findings include: On August 2, 2022, at 10:00 a.m., the surveyor was greeted at the front door by unlicensed personnel (ULP)-B. ULP-B was wearing a face mask over the nose and mouth. ULP-B did not have any form of eye protection on. ULP-B allowed the surveyor to enter licensee's building and escorted the surveyor to the community area where the surveyor was told to remain until licensed assisted living director (LALD)-D arrived. ULP-B did not screen the surveyor for signs and symptoms of COVID-19 or perform a temperature check. On August 2, 2022, at approximately 10:30 a.m., LALD-D entered the licensee's building wearing a face mask covering the nose and mouth. LALD-D was not wearing any type of eye protection.	0 510		

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0 510	Continued From page 13 During entrance conference on August 2, 2022, at 10:45 a.m., LALD-D stated she believed that current guidelines indicated there was no need for staff to wear eye protection due to COVID-19 infections rates being down for the county. LALD-D stated she had not reviewed the current transmission rates for COVID-19 cases. During entrance conference on May 3, 2022, at 10:45 a.m., LALD-D stated she believed that current guidelines indicated there was no need for staff to wear eye protection due to COVID-19 infections rates being down for the county. LALD-D stated she had not reviewed the current transmission rates for COVID-19 cases. The Minnesota Statewide Community Transmission level for the week of August 2, 2022, indciated the level was high transmission. The Minnesota Department of Health's COVID-19 PPE and Source Control Grids dated April 7, 2022, indicated all employees who work in a congregated health care setting, including assisted living facilities, are recommended to wear a face mask and eye protection when in areas they could encounter residents. The licensee lacked a Standard (Universal) Precautions for Infection Control policy with identification of when employees, residents, and visitors would be required to wear what personal protection equipment related to COVID-19 and lacked identification of when the licensee would screen and obtain temperature of employees, residents, and staff related to COVID-19. No further information provided. TIME PERIOD FOR CORRECTION: Two (2)	0 510		

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0 510	Continued From page 14 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 and interview, the licensee failed to post the required information related to the grievance procedure and contact information for the Offices of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all 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	0 550		

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0 550	Continued From page 15 a large portion or all of the residents). The findings include: On August 2, 2022, at approximately 11:30 a.m., during a facility tour, the surveyor did not observe a posting of the required grievance procedure, contact information for the Offices of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities, as well as information for reporting suspected maltreatment to (MAARC). On August 2, 2022, at approximately 12:05 p.m., licensed assisted living director (LALD)-D confirmed the above information was not posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.	0 580		

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0 580	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. 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 an interview on August 3, 2022, at 10:55 a.m., licensed assisted living director (LALD)-D stated she conducted staff meetings frequently to discuss resident care and concerns; however, had not developed any quality management activities. A policy related to quality management and addressing resident care and concerns was requested and not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c	0 640		

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0 640	Continued From page 17 The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 2, 2022, at approximately 10:45 a.m., the surveyor noted the facility's common areas had no posting of the 911 emergency number, or	0 640		

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0 640	Continued From page 18 information related to reporting suspected maltreatment to MAARC. During an interview on August 2, 2022, at 11:05 a.m., licensed assisted living director (LALD)-D verified the required information was not posted in the common areas. Policies related to posting information and phone numbers for reporting of maltreatment were requested and not provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	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	0 650		

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0 650	Continued From page 19 screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of one employee (unlicensed personnel (ULP)-B) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B had a hire date of August 2, 2021. ULP-B's record lacked documentation of a signed job description and orientation records including all required competency evaluations. During interview on August 2, 2022, at 12:00 p.m., licensed assisted living director (LALD)-D stated she believed ULP-B had the required	0 650		

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0 650	Continued From page 20 employee records but was not aware of where the records were located. LALD-D stated she would get the required employee records for surveyor to review. The licensee's staff orientation policy was requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers	0 660		

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0 660	Continued From page 21 for Disease Control and Prevention (CDC), which included a facility TB risk assessment. 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 August 2, 2022, at approximately 10:40 a.m. with licensed assisted living director (LALD)-D, they surveyor requested to review the facility TB risk assessment. LALD-D stated a facility TB risk assessment was completed but would need to look for a copy of the form. On August 2, 2022, at approximately 1:25 p.m., LALD-D brought to surveyor a copy of the licensee's TB risk assessment. TB risk assessment was dated October 1, 2017. LALD-D stated this was the only TB risk assessment that licensee had completed. The licensee's undated TB Prevention and Control policy indicated the registered nurse (RN) supervisor would be responsible for completing the licensee's TB risk assessment. The Minnesota Department of Health (MDH) guidelines, Regulations for TB Control in Minnesota Health Care Settings, dated June 10, 2019, and based on CDC guidelines, indicated a TB infection control program should include a	0 660		

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0 660	Continued From page 22 facility TB risk assessment performed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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:	0 680		

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0 680	Continued From page 23 Based on observation, interview and record review, the licensee failed to develop and maintain a written emergency disaster plan (EDP) with all required content and failed to post an emergency plan prominently. 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: During the entrance conference on August 2, 2022, at 10:25 a.m., licensed assisted living director (LALD)-D stated the licensee did not have an EDP binder. During observation on August 2, 2022, at approximately 11:45 a.m., the surveyor did not observe signage posted or information regarding the licensee's emergency plan or emergency exit diagrams at the licensee's entrance, on either floor, hallway, in the dining area, or in the living areas. The licensee's lacked an EDP with the following required components: -post an emergency disaster plan prominently -post emergency exit diagrams on all floors -program patient population -subsistence needs for staff and residents -tracking staff and residents -phone tree lacked phone numbers and names -volunteer policies and procedures -roles under a waiver declared by Secretary	0 680		

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0 680	Continued From page 24 -communication plan (listed hotel meeting sites, but lacked phone numbers/names) -sharing information occupancy needs -family notifications (blank form, no forms in resident records) -emergency prep testing requirements (blank test form in binder, no tests in staff training records) No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility fire extinguishers. 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	0 790		

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0 790	Continued From page 25 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: During the facility tour on August 3, 2022 between 11:00 a.m. and 12:00 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-D. During the facility tour, survey staff observed that the fire extinguishers were size 1A10BC, and they were not being inspected by an outside company. LALD-D verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
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.	0 810		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS CARE HOME LLC	514 BRITZ DRIVE LUVERNE, MN 56156

(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
0 810	Continued From page 26 (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, 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:	0 810		

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0 810	Continued From page 27 During interview on August 3, 2022 between 11:00 a.m. and 12:00 p.m., licensed assisted living director (LALD)-D stated they did not have fire and safety and evacuation plans on site. Survey staff requested fire safety training and evacuation plan documentation, but the licensee did not provide the requested documentation No additional information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced	01330		

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01330	Continued From page 28 by: Based on interview and record review, the licensee failed to complete training and competency evaluations in all required training topics for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B had a hire date of August 2, 2021. ULP-B's record lacked documentation of successful completion of training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform. On August 2, 2022, at 2:00 p.m., licensed assisted living director (LALD)-D verified ULP-B's record lacked evidence of completed training and competency testing in topics listed in 144G.61, subdivision 2. The licensee's training and competency policy were requested but not received.	01330		

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01330	Continued From page 29 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01330		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;	01370		

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01370	Continued From page 30 (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel ((ULP)-B), to include all required content, with training record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP- B was hired on August 2, 2021. ULP-B's training record lacked documentation of completed training and competency for the following: -maintenance of a clean and safe environment and -commonly used assistive devices. On August 2, 2022, at approximately 11:00 a.m., unlicensed personnel (ULP)-B stated they were not trained in the above identified areas prior to	01370		

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01370	Continued From page 31 providing services to residents. ULP-B stated they had been working in the same role for one year and provided cares to residents during that time. ULP-B stated they were trained and oriented to the needs of residents by the registered nurse (RN) that was employed for the licensee. On August 2, 2022, at approximately 11:20 a.m., LALD-D acknowledged ULP-B's record lacked documentation of the required training. LALD-D stated the training documentation lacking would have been completed onsite during orientation and orientation was conducted by an RN that was previously employed for licensee. On August 2, 2022, at approximately 1:50 p.m., RN-A stated she was unaware as to why ULP-B did not have required documentation. RN-A stated that a previous RN completed the training for ULP-B and no longer worked for licensee. The licensee's training and competency policy were requested but not received. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other	01380		

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01380	Continued From page 32 observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel (ULP)-B), to include all required content, with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B had a hire date of August 18, 2021. ULP-B's employee record lacked documentation of completed training and competency for the following: - observation, reporting, and documenting status, - basic body knowledge, - recognizing needs, - safe transfers, and	01380		

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01380	Continued From page 33 - range of motion. On August 2, 2022, at approximately 11:00 a.m., unlicensed personnel(ULP)-B stated they were not trained in the above identified areas prior to providing services to residents. ULP-B stated they had been working in the same role for one year and provided cares to residents during that time. ULP-B stated they were trained and oriented to the needs of residents by the registered nurse (RN) that was employed for the licensee. On August 2, 2022, at approximately 11:20 a.m., LALD-D acknowledged ULP-B's record lacked documentation of the required training. LALD-D stated the training documentation lacking would have been completed onsite during orientation and orientation was conducted by an RN that was previously employed for licensee. On August 2, 2022, at approximately 1:50 p.m., RN-A stated she was unaware as to why ULP-B did not have required documentation. RN-A stated that a previous RN completed the training for ULP-B and no longer worked for licensee. The licensee's training and competency policy were requested but not received. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an	01440		

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01440	Continued From page 34 appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing delegated tasks within 30 days of providing services for one of one unlicensed personnel ((ULP)-B) with employee record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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).	01440		

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01440	Continued From page 35 The findings include: ULP-B had a hire date of August 2, 2021. ULP-B was hired to provide direct care and services to the licensee's residents. ULP-B's employee record lacked documentation of an RN supervising ULP-B performing delegated tasks within 30 days of beginning to provide delegated duties. During interview on August 2, 2022, at 2:15 p.m., RN-A stated that she did not conduct official 30-day supervisory visits with ULPs performing delegated tasks. RN-A stated she did conduct supervisory visits to ensure staff were performing their job correctly, though she did not document these types of evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff received dementia training in the required areas for one of one employee (registered nurse (RN)-A) with employee records reviewed.	01490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01490	Continued From page 36 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 started employment with licensee on June 14, 2022. RN-A's employee file lacked evidence of completing dementia care training in the topics: - an explanation of Alzheimer's disease and other dementia's; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery. On August 2, 2022, at approximately 11:45 a.m., licensed assisted living director (LALD)-D acknowledged the RN-A's file was missing dementia care training and stated RN-A was in the process of completing this education. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01490		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility	01750		

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01750	Continued From page 37 must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel ((ULP)-B) who performed delegated tasks. 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: ULP-B started employment with licensee on August 2, 2021. ULP-B's employee record lacked evidence of completed training and competency evaluation for medication administration by a RN or other licensed health professional. On August 2, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-D stated	01750		

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01750	Continued From page 38 they were not trained in the above identified areas prior to providing services to residents. ULP-B stated they had been working in the same role for one year and provided cares to residents during that time. ULP-B stated they were trained and oriented to the needs of residents by the registered nurse (RN) that was employed for the licensee. On August 2, 2022, at approximately 11:20 a.m., LALD-D acknowledged ULP-B's record lacked documentation of the required training. LALD-D stated the training documentation lacking would have been completed onsite during orientation and orientation was conducted by an RN that was previously employed for licensee. On August 2, 2022, at approximately 1:50 p.m., RN-A stated she was unaware as to why ULP-B did not have required documentation. RN-A stated that a previous RN completed the training for ULP-B and no longer worked for licensee. The licensee's training and competency policy were requested but not received. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	01750		

DEPARTMENT OF HEALTH

Type: Full
Date: *08/02/22*
Time: 11:00:00
Report: 1033221079

Food and Beverage Establishment Inspection Report

Location:
Oasis Care Home Llc
514 Britz Drive
Luverne, MN56156
Rock County, 67

Establishment Info:
ID #: 0038294
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074496156
ID #:

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

The following orders were issued during this inspection.

3-500D Microbial Control: disposition of food

3-501.18A ** Priority 1 **

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

Facility is mixing their own sour cream and holding it past the seven day mark. Facility voluntarily discarded item.

Corrected on Site

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.

Facility does not have a test kit to measure the sanitizing solution they use.

Comply By: 08/16/22

2-400 Hygenic Practices

2-402.11

MN Rule 4626.0115 Food employees must wear an effective hair restraint, such as a hat, hair covering or hair net, a beard restraint and clothing to keep hair from contacting exposed food, clean equipment, utensils, linens, and unwrapped single-service or single-use articles.

Employee does not have a hair restraint.

Comply By: 08/02/22

Type: Full
Date: *08/02/22*
Time: 11:00:00
Report: 1033221079
Oasis Care Home Llc

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator Ambient Temperature
Violation Issued: No

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Freezer
Violation Issued: No

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

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

I acknowledge receipt of the inspection report number 1033221079 of 08/02/22.

Certified Food Protection Manager: Misty J Baker

Certification Number: FM 97872 Expires: 03/20/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Misty J Baker

Signed: _____
Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us