DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 26, 2022

Administrator
Serenity Assisted Living & Memory Care
1251 3rd Avenue Northwest
Dilworth, MN 56529

RE: Project Number(s) SL34017015

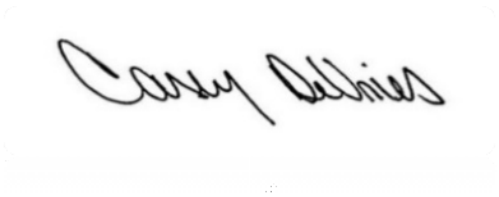
Dear Administrator:

On September 16, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the July 27, 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,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
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St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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Electronically Delivered

August 11, 2022

Administrator
Serenity Assisted Living & Memory Care
1251 3rd Avenue Northwest
Dilworth, MN 56529

RE: Project Number SL34017015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 27, 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 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,000.00. 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,

Jessie Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jessica.Chenze@state.mn.us
Phone: 218-332-5175| Fax: 218-332-5196

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34017	A. BUILDING: _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY ASSISTED LIVING & MEM	1251 3RD AVENUE NW DILWORTH, MN 56529

(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: SL#34017015 On, July 25, 2022, through July 27, 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 13 residents all whom were receiving services under the provider's Assisted Living with dementia license. An immediate correction order was identified on July 26, 2022, issued for SL#34017015, tag identification 2310. On July 27, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of H.	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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (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 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 25, 2022, for the specific Minnesota	0 480		

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0 480	Continued From page 2 Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content in common area to include posting the 911 emergency number in common areas and near telephones provided by the assisted living. This had the potential to affect all 13 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 640		

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0 640	Continued From page 3 During the facility tour on July 25, 2022, at approximately 12:20 p.m., the surveyor did not obverse 911 posted in the commons area as required. On July 25, 2022, at 3:00 p.m., agent (A)-A verified the 911 emergency number was not posted in the commons area or near the telephone positioned near the staff station, adjoining the commons area. A-A added some residents had personal phones in their rooms. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy dated August 1, 20221, noted the facility would post 911 emergency number in common areas and near telephones provided by the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
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;	0 680		

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0 680	Continued From page 4 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post an emergency preparedness plan prominently and failed to post emergency exit diagrams in prominent areas. This had the potential to affect all 13 residents receiving services under the assisted living with dementia license. 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 a tour of the facility on July 25, 2022, at approximately 12:20 p.m., the surveyor observed no signage of emergency exit diagrams in the facility's large open dining area, side sitting area,	0 680		

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0 680	Continued From page 5 or either of the two hallways. In addition, an emergency preparedness plan was not seen. On July 25, 2022, at 1:40 p.m., agent (A)-A verified one exit diagram was posted in the receiving garage [locked area] and one exit diagram was posted in the "mezzanine" [upstairs area used for staff training]. In addition, A-A stated exit diagrams were given to each resident at the time of move in. A-A stated they were waiting for the designer to get them made smaller. Owner (O)-B added diagrams would take away from person centeredness. A-A confirmed the emergency binder was not in a central location. The licensee's Disaster Planning and Emergency preparedness policy dated August 1, 2021, would be posted on each floor of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	0 970		

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0 970	Continued From page 6 Based on interview and record review, the licensee failed to ensure the assisted living with dementia care contract did not include language waiving the facility's liability for health, safety, or personal property for two out of two residents (R1, R2). 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 of the residents). The findings include: On July 26, 2022, at approximately 11:00 a.m., R1 and R2 records were requested for review. R1 and R2's assisted living contracts, dated April 7, 2022, and August 1, 2021, respectively, included the following language: Page 9, of the contract, under "Insurance & Liability" heading noted the resident would hold the facility harmless for any loss, damage, injury or expense incurred by the resident as a result of careless, negligent, or willful acts of the resident. Further, the resident would be responsible for any loss, damage, injury, or expense incurred by the facility, or other resident's, guests, or other persons on the property which are the result of careless, negligent, or willful acts, including improper use of appliances, plumbing fixtures, etc., by the resident. You are liable for any loss or damage to your personal property except if caused by our gross negligence. The facility is not	0 970		

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0 970	Continued From page 7 responsible for any personal property damage or loss from fire, smoke, rain, flood, water and pipe leaks, hail ice, snow, lighting, wind, explosions, earthquake, interruption of utilities, theft, hurricane, negligence of other residents, occupancies, or invited/uninvited guests or vandalism unless otherwise required by law. On July 26, 2022, at 1:03 p.m., agent (A)-A acknowledged the contract included a liability waiver. A-A confirmed the same assisted living contract was used for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record,	01640		

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01640	Continued From page 8 including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure individual service plans were revised to reflect the current services provided for two of two residents (R1, R2) 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included, Alzheimer's dementia, arthritis, left hip replacement, left knee replacement and hypertension (high blood pressure). R1's Service Plan dated July 19, 2022, indicated the resident received the following services: assistance with activities of daily living (ADLs), peri care and compression stockings (TEDs), appointment reminders, bathing two times a week, bed making, behavior management/redirection tracking, behavior	01640		

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01640	Continued From page 9	01640		

monitoring/intervention/redirection, COVID-19 symptom screen, foot/nail care by nurse, weekly housing keeping, laundry, 2 loads a week, laundry/linens, meal intake, meal reminders, medication management, toileting assistance and monitoring of vital signs.

R1's assessment dated July 19, 2022, indicated R1 was independent with choosing clothing and was able to dress self. Staff was to offer assistance as needed with buttons, snaps, zippers, jewelry, socks, shoes and clothing that may be on backwards or inside out.

On July 26, 2022, at 8:05 a.m., the surveyor observed R1 sitting on the side of the bed holding onto the grab bar attached to the bed. ULP-E suggested to R1 to go the bathroom. ULP-E put shoes on R1 and R1 ambulated to the bathroom using a walker and sat on the toilet. ULP-E applied TEDs to R1's legs and then dressed R1's lower body with pants. ULP-E gave R1 a wet warm washcloth and instructed R1 to clean her peri area. R1 then walked to a chair in the living area and sat down. R1 was wearing the shirt she slept in. ULP-E asked her if she wanted to wear that shirt under a new shirt or to remove it. R1 was not sure what to do. ULP-E suggested to R1 to remove the shirt and use it again for sleeping attire. ULP-E gave R1 a choice of three shirts to wear for the day. R1 asked about the forecasted weather and chose one. ULP-E assisted R1 with guiding the shirt into place. ULP-E then administrated R1's morning medications and asked R1 if she wanted to go to the dining room for breakfast or wait and go later. R1 accepted ULP-E escort to the dining area.

On July 26, 2022, directly following this observation at approximately 8:30 a.m., the

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01640	Continued From page 10	01640		

surveyor interviewed ULP-E regarding services performed. ULP-E replied R1 sometimes walks to the dining room by herself.

On July 26, 2022, at approximately 12:15 p.m., registered nurse (RN)-C verified R1's service plan did not include dressing assist. RN-C added when she asked R1 about those services R1 replied she can dress herself.

R2
R2's diagnoses included vascular dementia, high blood pressure and anxiety.

R2's Service Plan dated May 1, 2022, included dressing, oral care, shaving, skin care, TEDs, ambulation/transferring/exercise, bathing two times a week, behavior management-redirection/tracking, monitoring/intervention/redirection, bowel movement monitoring, COVID-19 symptom screen, foot/nail care by nurse, housekeeping weekly, laundry meal intake, medication assist, pendant call light, sleep log, toileting assistance and vital sign monitoring. R2's service plan did not include escorts.

R2's Master Care Plan dated July 8, 2022, included does not require escorts, client is independent with 4 wheeled walker (4WW), needs supervision intermittently and does not use a wheelchair, needs reminders and supervision for grooming and hygiene, needs supervision intermittently with mobility/transfers, one person assist under the arm boost for assistance with standing from a sitting position.

On July 26, 2022, at 9:04 a.m., the surveyor observed R2 sitting in a wheelchair in R2's room. ULP-E was putting clothes in R2's closet. R2 was

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SERENITY ASSISTED LIVING & MEM	1251 3RD AVENUE NW DILWORTH, MN 56529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 11 dressed and groomed. ULP-E applied pedals to the wheelchair R2 was sitting in and asked R2 to put her feet on the pedals. R2 let her feet hang over the wheelchair pedals, not following ULP-E's instructions. ULP-E removed the wheelchair pedals and instructed R2 to lift her feet. ULP-E started to push the wheelchair but stopped since R2 did not follow the direction to lift her feet. ULP-E reapplied the wheelchair pedals and placed R2s feet onto them. ULP-E wheeled R2 to the dining area. On July 27, 2022, at approximately 12:25 p.m., RN-C confirmed R2's service plan had not been updated with the additional services that were now provided. RN-C added she was in the process of arranging hospice services. The licensee's Service Plan policy dated August 1, 2021, indicated services plans would be revised, if needed, based on resident reassessments and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring	01650		

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01650	Continued From page 12 assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1	01650		

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01650	Continued From page 13 R1's diagnoses included, Alzheimer's dementia, arthritis, left hip replacement, left knee replacement and hypertension (high blood pressure). R1's Service Plan dated July 19, 2022, indicated the resident received the following services: assistance with activities of daily living (ADLs), peri care and compression stockings (TEDs), appointment reminders, bathing two times a week, bed making, behavior management/redirection tracking, behavior monitoring/intervention/redirection, COVID-19 symptom screen, foot/nail care by nurse, weekly housing keeping, laundry, 2 loads a week, laundry/linens, meal intake, meal reminders, medication management, toileting assistance and monitoring of vital signs. R1's Service Plan lacked the following required content: - the method of monitoring staff providing services. R2 R2's diagnoses included vascular dementia, high blood pressure and anxiety. R2's Service Plan dated May 1, 2022, included dressing, oral care, shaving, skin care, TEDs, ambulation/transferring/exercise, bathing two times a week, behavior management-redirection/tracking, monitoring/intervention/redirection, bowel movement monitoring, COVID-19 symptom screen, foot/nail care by nurse, housekeeping weekly, laundry meal intake, medication assist, pendant call light, sleep log, toileting assistance and vital sign monitoring. R2's service plan did not include escorts.	01650		

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01650	Continued From page 14 R2's Service Plan lacked the following required content: - the method of monitoring staff providing services. On July 27, 2022, at 10:04 a.m., registered nurse (RN)-C verified R1 and R2's service plans were incomplete and did not include the above noted content. RN-C confirmed all the service plans would be missing the method of monitoring staff providing services. The licensee's Service Plan policy dated August 1, 2021, indicated service plans would include a schedule and method for the next unplanned monitoring of staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must	01690		

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01690	Continued From page 15 address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure accountability of controlled substances was maintained for one of one resident (R7) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 July 25, 2022,	01690		

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01690	Continued From page 16 at approximately 12:00 p.m., registered nurse (RN)-C confirmed the licensee provided medication management services for residents at the facility and some residents had a controlled substance prescribed. R7's diagnoses included edema, high cholesterol, hypertension (high blood pressure) and Alzheimer's dementia. R7's service plan dated January 1, 2022, indicated R7 received medication management services. On July 25, 2022, at 1:20 p.m., the surveyor and registered nurse (RN)-C reviewed the contents of the locked medication cabinet drawer in R7's room. A prescription bottle labeled lorazepam (a level IV (4) controlled substance used to treat anxiety) 0.5 milligrams (mg) was identified. RN-C counted the pills and found there to be 23 half tablets in the prescription bottle. RN-C confirmed there was not a narcotic log (a record where staff document the removal and addition of the identified controlled substance) for R7's bottle of lorazepam. RN-C stated the licensee's policy was to double lock and count scheduled II drugs (substances that have a high potential for abuse or dependence). RN-C confirmed there were other narcotics used at the facility that were not counted, adding only schedule II drugs are counted or double locked. The licensee's Medication Storage policy dated August 1, 2021, indicated Schedule II Drugs would be stored under a double lock system and stored separately from other medication. Schedule II drugs would be counted at the beginning and end of every shift, with counts compared to Schedule II medications ordered to	01690		

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01690	Continued From page 17 be administered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for two of two residents (R1, R2) with records reviewed. In addition, the licensee failed to ensure the RN trained the unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident, and failed to ensure the ULP demonstrated the ability to competently follow the procedure to perform the tasks for one of one employees (ULP-E).	01750		

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01750	Continued From page 18 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: SPECIFIC RESIDENT INSTRUCTIONS R1 R1's record lacked specific written instructions regarding the administration of eye drops. R1's diagnoses included Alzheimer's dementia, arthritis, left hip replacement, left knee replacement and hypertension (high blood pressure). R1's Service Plan dated July 19, 2022, indicated the resident received medication assist. R1's physician's orders dated April 14, 2022, included Pred Forte 1% (nonsteroidal anti-inflammatory [swelling] eye medication) 1 drop in both eyes daily. The manufacturer's instructions for Pred Forte 1% dated April 21, 2022, indicated to shake well before using. The licensee failed to have instructions to shake the eye drops shaken prior to administration on the medication administration record (MAR.) On July 27, 2022, at 10:01 a.m., registered nurse (RN)-C verified R1's MAR lacked to include	01750		

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01750	Continued From page 19 specific instructions for R1's eye medication. RN-C added "how do you know you are supposed to shake that one?" R2 R2's record lacked specific written instructions regarding medications, specifically, which mediations were able to be crushed. R2's diagnoses included vascular dementia, high blood pressure and anxiety. R2's Service Plan dated May 1, 2022, included medication assist and medications could be crushed as needed (PRN). R2's physician's orders dated January 19, 2022, included potassium chloride 10 milliequivalents (mEq) 1 time a day (blue, white or orange/white capsule). On July 27, 2022, at approximately 10:05 a.m., RN-C confirmed R2's MAR lacked to include specific instructions for R2's medication. RN-C pointed to a place on the MAR to indicate which medication should be opened not crushed. PERFORMING DELEGATED TASK: CRUSHING MEDICATION On July 27, 2022, at approximately 9:25 a.m., ULP-E removed a 7 day medication planner (pre-filled dosage box) from a locked cabinet in R2's room and removed 13 medications from the planner using a tweezer and placed them into a medication cup. ULP-E took the medication cup to a staff working station behind a locked door. Using a tweezer ULP-E removed a capsule from the medication cup opened it and put the contents into a new medication cup. ULP-E then	01750		

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01750	Continued From page 20 removed 2 pills, crushed them, and added them to the new medication cup. ULP-E removed 3 pills, 5 pills, and 1 medication respectively crushing them and adding them to the medication cup. ULP-E added pudding to the medications and administrated them to R2. On July 27, 2022, at 12:24 p.m., registered nurse (RN)-F verified ULP-E had not been trained by RN how to crush medications, adding ULPs were trained on the floor by other ULPs. RN-F confirmed none of the ULP's were not trained by RN to crush medications. The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated the RN would specify, in writing, specific instructions for each resident and document those instructions in the resident's record. In addition, the RN would ensure that prior to the delegation the ULP is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated	01890		

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01890	Continued From page 21 drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for four of four residents (R5, R6, R8, R9) and failed to monitor for expired medications for two out of six residents (R7, R9). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 25, 2022, at approximately 12:40 p.m., the surveyor toured the facility with registered nurse (RN)-C including a review of the locked edification drawers in resident rooms. RN-C observed and confirmed the following.: DATING OF TIME SENSITIVE MEDICATIONS R5's opened bottle of latanoprost 0.005% ophthalmic (eye) solution (glaucoma medication) did not have a label which indicated the date the eye drop solution had been opened and when the solution would expire. R6's opened travoprost ophthalmic 0.04% (glaucoma medication) solution lacked a label to	01890		

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01890	Continued From page 22 indicate the date the eye drop solution was opened and when the solution would expire. R8's opened travoprost ophthalmic 0.004% lacked a label to indicate the date the eye drop solution was opened and when the solution would expire; and opened Timolol Maleate 0.5% eye solution (used to treat increased pressure in the eye) lacked a label to indicate the date the eye drop solution was opened and when the solution would expire. R9's opened Systane Ultra 0.4-0.3% eye drops (used for dry eye) lacked a label to indicate the date the eye drop solution was opened and when the solution would expire. The manufacturer's instructions for latanoprost dated October 2019, directed to discard any unused solution after 42 days. The manufacturer's instructions for travoprost eye drop solution dated February 2022, directed to discard the bottle four (4) weeks after it has been opened. The manufacturer's instructions for Timolol dated October 2019, directed to discard any unused solution after four (4) weeks. The manufacturer's instructions for Systane dated April 26, 2018, directed to discard any unused solution after 30 days. EXPIRED MEDICATIONS R7's loperamide (treatment of loose stools) 2 milligram (mg) tablets expired February 17, 2022. R9's ear wax removal aide expired June 2015.	01890		

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01890	Continued From page 23 On July 25, 2022, at directly following the above observation RN-C confirmed time sensitive medications should be dated with a when opened and expiration date. In addition, RN-C added expired medications should have been removed from the medication drawer. The licensee's Medications-Prescription Drugs & Prohibition policy dated August 1, 2021, indicated prescription drugs would be labeled with legible information to include the expiration or beyond-use date of a time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable,	01910		

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01910	Continued From page 24 quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of all medications to include the medication strength, prescription number, and quantity for all medications for one of one discharged resident (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 was admitted for services on November 30, 2021, and discharged on May 10, 2022. R3's service plan dated April 13, 2022, indicated the resident received medication management services which included medication administration. R3's medication administration record (MAR) dated May 2022, included the following medications: lorazepam (anxiety) 0.5 milligrams (mg) every 4 hours, morphine sulfate (moderate to severe pain) 6 mg every 4 hours, carvedilol (high blood pressure) 6.25 mg twice daily, hydralazine hydrochloride (high blood pressure)	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34017	A. BUILDING: _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY ASSISTED LIVING & MEM	1251 3RD AVENUE NW DILWORTH, MN 56529

(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
01910	Continued From page 25 50 mg 1.5 tabs three times a day, Vani cream HC (rash) twice daily, Lasix (diuretic) 80 mg daily, amlodipine (high blood pressure) 10 mg daily, doxazosin mesylate (high blood pressure) 4 mg daily, R3's prescriber orders dated April 15, 2022, included all of the above noted medications. R3's record lacked documentation for the disposition of the medications, carvedilol, hydralazine hydrochloride, Vani cream, Lasix, amlodipine, and doxazosin mesylate. On July 26, 2022, at 12:15 p.m., registered nurse (RN)-C verified not all of R 3's medications were listed on R3's discharge record. RN-C stated she was not "here" [at facility], adding from her understanding medications in the medication planner went back to the pharmacy. The licensee's Medication Disposal policy dated August 1, 2021, indicated the facility would document in the resident's record the disposition of the mediations including the medications name, strength, prescription number as applicable, quantity, to whom the medication was given, date of disposition, and names of staff and other individuals involved in the deposition. In addition, controlled substances must be disposed of in accordance with accepted practices of the Minnesota Board of Pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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02170	Continued From page 26	02170		
02170 SS=E	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities.	02170		

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02170	Continued From page 27 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R1, R2) who received services under an assisted living with dementia care license with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included, Alzheimer's dementia, arthritis, left hip replacement, left knee replacement and hypertension (high blood pressure). R1's Individual Activity Plan dated July 19, 2022, included previous and current interests, cognitive activities, and adaptations necessary for the resident to participate. R1's activity plan did not include the following: - physical abilities and limitation; - emotional and social needs and patterns; and - identification of activities for behavioral interventions. R2	02170		

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02170	Continued From page 28 R2's diagnoses included vascular dementia, high blood pressure and anxiety. R2's Individual Activity Plan dated July 8, 2022, included current interests, both cognitive and physical activities. In addition, plan included adaptations necessary for the resident to participate. R2's activity plan did not include the following: - past interests; - physical abilities and limitation; - emotional and social needs and patterns; and - identification of activities for behavioral interventions. On July 27, 2022, at approximately 10:30 a.m., registered nurse (RN)-C verified R1's and R2's individual activity plan lacked all required information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=H	144G.91 Subd. 4 Appropriate care and services (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 three of four	02310		

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02310	Continued From page 29 residents (R1, R4, R5) with side rails. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: This practice resulted in an immediate correction order on July 26, 2022. R1 On July 26, 2022, at 8:05 a.m., the surveyor observed R1 sitting on the side of her bed holding onto a u-bar type side rail that was secured to the bed. The bottom of the u-bar fit between the mattress and box spring and did not easily move out or back in. During the observation, R1 used the u-bar to steady herself while sitting on the side on the bed and later she used it to assist herself into a standing position. R1's diagnoses included, Alzheimer's dementia, arthritis, left hip replacement, left knee replacement and hypertension (high blood pressure.) R1's service plan dated July 19, 2022, indicated the resident received the following services: assistance with activities of daily living (ADLs), peri care, compression stockings (TEDs), appointment reminders, bathing two times a week, bed making, behavior	02310		

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02310	Continued From page 30	02310		

management/redirection tracking, behavior monitoring/intervention/redirection, COVID-19 symptom screen, foot/nail care by nurse, weekly housing keeping, laundry, 2 loads a week, laundry/linens, meal intake, meal reminders, medication management, toileting assistance and monitoring of vital signs.

R1's Assessment dated July 19, 2022, indicated R1 uses a bed cane for additional assistance with bed mobility and safety.

R1's record included Safe-Bed Safety assessment:
-August 18, 2018, bed type: electric (ended July 26, 2022);
-August 30, 2018, mattress type: mattress original to bed;
-September 4, 2019, bed rails in use; partial side rail (ended July 25, 2022);
-February 28, 2022, rationale for side rails: to aid in transfers to and from bed;
-February 28, 2022, side rail is appropriate, based upon need and assessment.
-July 25, 2022, bed rails in use; Bed cane to use for positioning; and
-July 26, 2022, specify bed type: standard bed frame.

R1's record included Straight A's to Bed Cane Assistance and Safety document dated September 5, 2019. It included a statement that the resident had been informed on entrapment and safety risks involved with bed canes and education was provided by registered nurse (RN). The assessment did not state if the rail had not been discontinued.

On July 26, 2022, at 2:20 p.m., RN-C handed the surveyor the manufacturer's instructions for R1's

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02310	Continued From page 31 bedrails she found under "miscellaneous" in R1's record. RN-C added, "I am not sure where it [instructions]came from." R4 R4's diagnosis included, Alzheimer's, chronic obstructive pulmonary disease (COPD) [a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation], hypertension (high blood pressure) and anemia. R4's service plan dated June 14, 2022, indicated the resident received the following services: assistance with ADLs- dressing, grooming, nail care, shaving, bathing two times a week, bed making, behavior monitoring/ intervention/redirection, bowel movement monitoring, COVID-19 symptom screen, escort assist, foot/nail care by nurse, weekly housing keeping, laundry, 2 loads a week, laundry/linens, meal intake, meal reminders, medication management, pacemaker check, sleep log, toileting assistance, PT/INR check [test to measure the time it takes for a clot to form in a blood sample] and monitoring of vital signs. R4's Assessment dated July 14, 2022, indicated R4 is independent with bed mobility and can transfer safely without help. R4's Bed Cane assessment dated July 2, 2022, included the client has an alteration in safety awareness due to cognitive decline. Bed cane would promote resident independence. R4 has a history of falls and displays poor bed mobility or difficulty moving to a sitting position, has poor truck control and interventions to limit restrictions have been implemented.	02310		

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02310	Continued From page 32 R4's Bed Safety assessment dated May 31, 2022, included bed cane in use for positioning and transferring and power of attorney (POA) signed the assessment form. The form does not include the rationale, if appropriate, if there were any alternatives that could be used in place of the bed rails, if education was provided to the resident/responsible party of the risks and benefits of the bed rails and was understanding verbalized, and if bed rails were installed and maintained according to manufacturer instructions. R5 R5's diagnosis included Alzheimer's, arthritis, anxiety, and hypertension. R5's service plan dated June 21, 2022, indicated the resident received the following services: assistance with ADLs- dressing, eye glass assistance, grooming, nail care, oral care, peri care, skin care, bathing two times a week, bed making, behavior monitoring/intervention/redirection, COVID-19 symptom screen, hair appointments, escort assist, foot/nail care by nurse, weekly housing keeping, laundry, 2 loads a week, laundry/linens, meal intake, nutritional supplements two times a day, medication management, pacemaker check, sleep log, toileting assistance, and monitoring of vital signs. R5's assessment dated June 21, 2022, indicated R5 required limited assist with bed mobility, assist with getting resident in and out of bed and uses an assistive device to aid positioning, bed cane. R5's Bed Cane assessment dated June 21, 2022, included the client has an alteration in safety awareness due to cognitive decline. Bed cane	02310		

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02310	Continued From page 33 would promote resident independence. R5 has a history of falls and displays poor bed mobility or difficulty moving to a sitting position, has poor truck control, would use the bed can for positioning or support, and interventions to limit restrictions have been implemented. On July 26, 2022, at 2:15 p.m., licensed assisted living director (LALD)-A confirmed the manufacturer's instructions for R4 and R5 were not the correct ones. LALD-A added if you are looking for the new bedrail guidance that came out in June you are not going to find it. On July 26, 2022, at 3:47 p.m., RN-C stated "I can only speak for myself and I did not investigate any of the bedrails/ canes used for any recalls. The licensee's Side rails/Bed Cane policy revised August 1, 2021, indicated when utilizing side rails on a bed they would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risk and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. The policy included the side rail deign was to be consistent with the Food and Drug Administration (FDA) 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1, 2, and 3 must not exceed 4. 75". The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain,	02310		

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02310	Continued From page 34 uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed by surveyor's on-site obseravation on July 27, 2022, and review by evaluation supervisor on July 27, 2022; however, non-compliance remains at pattern level three (H). TIME PERIOD FOR CORRECTION: Two (2) days	02310		
02410 SS=E	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in	02410		

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02410	Continued From page 35 the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure privacy was maintained for two of four residents (R11, R2) observed during meditation administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R11 R11's oral and eye drop medication administration was conducted while R11 was seated in the occupied open dining room area by unlicensed personnel (ULP)-D. R11's diagnoses included dementia. R11's Service Plan dated May 17, 2022, included medication administration up to four times a day.	02410		

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02410	Continued From page 36 On July 26, 2022, at 8:41 a.m., R11 was seated in the open dining area that contained four tables. R11 was sitting at a table with one other resident. There were 7 residents in the dining area at that time. With gloved hands ULP-D approached R11 with a medication cup that contained R11's crushed morning medication mixed with jelly and a bottle of eye drops. ULP-D did not encourage, offer, or attempt to direct R11 to a private area. ULP-D put a spoonful of the mixture up to R11's mouth. After R11 swallowed the medication mixture ULP-D instructed R11 to tip her head back "just a little for me, can you?" ULP-D then tipped her head back indicating what R11 was to do. ULP-D then administered an eye drop in each of R11's eyes. On July 26, 2022, directly following the above observation, at approximately 8:44 a.m., ULP-D stated "yes and no, she was telling me she was tired and hungry, it might be allowed in memory care?" in regard to if medication administration was allowed in non-private areas. R2 R2's oral medication administration was conducted while seated in the occupied open dining room area by ULP-E. R2's diagnoses included vascular dementia, high blood pressure and anxiety. R2's Service Plan dated May 1, 2022, included medication administration up to five times a day. On July 26, 2022, at 9:36 a.m., R2 was seated in the open dining area at a table by herself. There were 6 residents in the dining area at that time. ULP-E approached R2 with a medication cup that	02410		

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02410	Continued From page 37 contained R2's crushed morning medication mixed with vanilla pudding. ULP-E did not offer, encourage or attempt to direct R2 to a private area. ULP-E fed the contents of the medication cup to R2. On July 26, 2022, at approximately 10:00 a.m., registered nurse (RN)-C stated, "at the other house [assisted living facility] we don't allow medications at the table." RN-C confirmed R2 and R11's medication plans did not include a statement allowing medications to be given at the dining room table. The licensee's Medication Management Individualized Plan policy dated August 1, 2021, indicated the individualized medication management record would contain specific resident instructions relating to the administration of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *07/26/22*
Time: 12:21:41
Report: 7935221175

Food and Beverage Establishment Inspection Report

Location:
Serenity Assisted Living & Mem
1251 3rd Avenue Nw
Dilworth, MN56529
Clay County, 14

Establishment Info:
ID #: 0038829
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2184777254
ID #:

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

The following orders were issued during this inspection.

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

DOMESTIC CROCK POTS - THEY WERE REMOVED DURING INSPECTION.

Corrected on Site

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Three Comp Sink
Violation Issued: No

Hot Water: = at 165 Degrees Fahrenheit
Location: Dish Machine #1
Violation Issued: No

Hot Water: = at 165 Degrees Fahrenheit
Location: Dish Machine #2
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Aurora - Single Door Cooler
Violation Issued: No

Type: Full
Date: *07/26/22*
Time: 12:21:41
Report: 7935221175
Serenity Assisted Living & Mem

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Aurora - Double Door Cooler
Violation Issued: No

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

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

I acknowledge receipt of the MN Department of Health inspection report number 7935221175 of 07/26/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____ Signed: 7935

Establishment Representative 7935

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