Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307212023M
Compliance #: HL307213748C

Date Concluded: January 12, 2023

Name, Address, and County of Licensee Investigated:
Villa Vista and Cardinal Court
1220 Villa Court Drive
Cromwell MN, 55726
Carlton County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Not Substantiated

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when they failed to provide supervision and the resident jumped out of a second story window.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. There was not a preponderance of evidence to support the facility failed to provide supervision. Staff provided meals and medications to the resident the day of the incident. During interviews staff members stated there were no changes with the resident and there was no history of the resident making statements he wanted to hurt himself or discuss plans to hurt himself.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigation included review of the resident's medical record, service delivery records, medication administration records, staff communication logs, internal investigation, incident reports, death record, and policy and procedures related to service plans,

individual abuse prevention plans, and maltreatment. Also, the investigator observed staff providing services to other residents at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included angina (chest pain) and hypertension (high blood pressure). The resident's service plan included assistance with bathing, medication administration, and food preparation. The residents service delivery record indicated the resident received safety checks twice daily. The resident's assessment indicated the resident was alert and oriented.

The resident's incident report, internal investigation, and discharge summary indicated at 12:40 p.m., the resident cut through his window screen in his room, leapt through the window, and fell two stories to drain rocks below. Staff members outside on break seen the resident jump, yelled out to call 911, and ran to the resident. The resident was awake and talked while waiting for the ambulance to arrive. When asked why he jumped, the resident stated he was sick of living, and he was old enough. The resident transported to the hospital and passed away at approximately 4:00 p.m.

The resident's death record indicated cause of death was blunt abdominal trauma and descent from window.

The resident's medication administration record indicated the resident received 8:00 a.m. medications the day of the incident.

The residents progress notes and staff communication logs did not indicate any changes with the resident prior to the incident.

During an interview, unlicensed personnel (ULP) 1 stated she worked with the resident the day before the incident. ULP 1 stated she did not see any changes with the resident that day or when she worked with the resident the week before. ULP 1 stated the resident received safety checks daily and staff administered medications. ULP 1 stated the resident was alert and oriented. The resident had a pull cord and call pendent to request staff assistance.

During an interview, ULP 2 stated she worked with the resident the day he leapt out the window. ULP 2 stated she administered the resident's morning medications at 8:30 a.m. and delivered breakfast. After breakfast, ULP 2 picked up the resident's breakfast dishes and overheard the resident talking on the phone with a family member. ULP 2 stated it was a normal conversation and there was nothing abnormal about the phone call. Between 11:15 a.m. and 11:30 a.m., she delivered the resident lunch. ULP 2 stated there was nothing out of the ordinary with him at lunch time. Between 12:30 and 1:00 p.m., ULP 2 stated she heard staff members outside on break in the parking lot screaming the resident jumped out the window. She ran outside to check on the resident and called 911. ULP 2 stated she worked with the resident the week before the incident and there was nothing abnormal or different. ULP 2 stated she had worked with the resident since admission to the facility. ULP 2 stated the

resident had not made any statements about wanting to hurt himself or discuss plans to hurt himself.

During an interview, ULP 3 stated she worked with the resident the week before the incident. ULP 3 stated there was nothing abnormal or different with the resident. ULP 3 stated the resident was alert, oriented, knew how to use his call pendent, and would use his call pendent to call for staff assistance.

During an interview, the nurse stated two staff members were outside in the parking lot on break. The resident pushed on his living room window screen and then walked away. The nurse stated the staff members did not think anything of it or see a concern because the resident had a history of touching and fixing things throughout the facility to see how they worked. When they looked up again the resident had jumped out his bedroom window. The nurse stated when they entered the resident's room there was a table knife on the resident's windowsill. The resident used the knife to create a flap in the bedroom window screen. She conducted an internal investigation and spoke to staff who worked with the resident. Staff reported nothing different with the resident. The nurse stated she had taken care of the resident since his admission. She stated the resident had not made any statements he wanted to hurt himself or discuss plans to hurt himself. Three days prior to the incident she seen the resident. She stated nothing was different. The nurse stated the resident would talk freely with her and would frequently visit with her in her office. She stated there was no indication to surmise that an incident like this was going to happen.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, the resident was deceased.
Family/Responsible Party interviewed: No, declined to interview.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility sent the resident to the hospital for evaluation and conducted an internal investigation.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30721	A. BUILDING: _____ B. WING _____	C 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA VISTA AND CARDINAL COURT	1220 VILLA COURT DRIVE CROMWELL, MN 55726

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: **Revised** #HL307213748C/#HL307212023M On November 22, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 48 residents receiving services under the provider's Assisted Living license. The following correction orders with a period to correct that are not immediate are issued for #HL307213748C/#HL307212023M , tag identification, 630, 910, 920, 930, 940 and 950. The immediacy for correction order for #HL307213748C/#HL307212023M, tag identification 0510 was removed. However, non-compliance remains at a scope and level of	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.	

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0 000	Continued From page 1 F.	0 000		
0 510 SS=I	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 review the facility failed to establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control related to COVID-19. The deficient practice had the potential to effect 48 out of 48 residents. 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 of all residents). Findings include:	0 510		

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0 510	Continued From page 2 Personal Protective Equipment The licensee failed to ensure staff wore personal protective equipment (PPE) per CDC and the MDH guidelines. The MDH guidance titled, COVID-19 PPE and Source Control (Masking), PPE, and Testing Grid, dated November 2, 2022, indicated when entering a room of a resident who tested positive for COVID-19 and was on transmission-based precautions staff wore full COVID-19 PPE: respirator, eye protection, isolation gown, and gloves. The same guidance indicated the facility should consider universal use of N95's and protective eyewear when the facility was in an outbreak. On November 22, 2022, at 8:45 a.m., the evaluator entered the facility. Staff observed in communal spaces, walking up and down halls past residents. Staff wore facemasks, no eye protection, or N95 respirators. On November 22, 2022, at 8:55 a.m., registered nurse (RN)-D stated the licensee had three COVID-19 positive residents on transmission-based precautions in the building. RN-D stated the licensee's next facility wide testing date was November 23, 2022. The licensees COVID-19 positive residents on transmission-based precautions included three residents (R2, R3, R4) R2 R2's diagnoses included type II diabetes, and chronic respiratory failure.	0 510		

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0 510	Continued From page 3 R2's record indicated R2 tested positive for COVID-19 on November 18, 2022. R2's care plan indicated R2 required assistance with bathing, blood sugar checks, medication administration, stand by assist for walking, and food preparation. The same care plan indicated R2 required as needed assistance with dressing, grooming, and toileting. R3 R3's diagnoses included hypertension and peripheral vascular disease. R3's record indicated R3 tested positive for COVID-19 on November 18, 2022. R3's care plan indicated R3 required assistance with dressing, bathing, toileting, medication administration, and food preparation. R4 R4's diagnoses included dementia. R4's record indicated R4 tested positive for COVID-19 on November 16, 2022. R4's care plan indicated R4 required assistance with bathing, medication administration, and food preparation. On November 22, 2022, at 9:10 a.m., outside R2's room a PPE table observed with gowns, facemasks, hand sanitizer, two eye googles, and gloves. N95 respirators were not observed on the PPE table. R2's room door was open. No signage posted indicating R2 was on transmission-based precautions. A garbage can observed under the PPE table in the communal hallway with used disposable gowns.	0 510		

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0 510	Continued From page 4 On November 22, 2022, at 9:15 a.m., activities director (AD)-I was observed wearing a facemask, no eye protection or N95 respirator. AD-I stated she provided activities to residents. On November 22, 2022, at 9:20 a.m., unlicensed personnel (ULP)-A was observed at the nurse's station. ULP-A wore a facemask, no eye protection, or N95 respirator. ULP-A left the nurse's station and stated she was on her way to clean a resident's room. ULP-A stated she provided cares to residents, cleaned rooms, and assisted with meal delivery. On November 22, 2022, at 9:20 a.m., ULP-B entered a resident's room, to make a bed. ULP-B wore a facemask, no eye protection, or N95 respirator. ULP-B stated she administered medications to residents, provided care, and assisted with meal delivery. On November 22, 2022, at 9:35 a.m., ULP-B stated staff do not wear eye protection and stated she did not know if staff needed to wear eye protection. ULP-B stated staff do not wear N95 respirators and were not required to do so when entering R2, R3, or R4's rooms who were all on transmission-based precautions for COVID-19. ULP-B stated she did not wear a N95 respirator, gown, or eye protection when she administered medications this morning to R2 and R3. On November 22, 2022, at 9:40 a.m., AD-I was observed in R2's room. AD-I wore a facemask, no eye protection, no gown, no gloves, or N95 respirator. On November 22, 2022, at 9:40 a.m., AD-I verified she exited R2's room who was	0 510		

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0 510	Continued From page 5 transmission-based precautions for COVID-19. AD-I stated she did not wear a N95 respirator, eye protection, gown, or gloves, when entering R2's room who was on transmission-based precautions. AD-I stated she just went in to say "hi" and stated she should have worn full PPE when entering R2's room. On November 22, 2022, at 10:15 a.m., ULP-A stated she delivered meals to R2, R3, and R4's rooms. ULP-A stated she did not wear a N95 during meal delivery, and all staff wore facemasks not N95's when delivering meals. On November 22, 2022, at 10:40 a.m., RN-E stated the licensee has had a six residents test positive and one staff member test positive for COVID-19 in the last two weeks. RN-E stated three residents were off transmission-based precautions and three (R2, R3, R4) were currently on transmission-based precautions. RN-E stated the licensee did not require staff to wear N95 respirators when entering R2, R3, or R4's rooms. RN-E stated staff should wear full PPE including a N95 respirator, gown, gloves, and eye protection when entering R2, R3, and R4's room. RN-E stated the licensee had N95 supply available. RN-E stated she did not post signage on R2, R3, and R4's room door indicating they were on transmission-based precautions. On November 22, 2022, 10:45 a.m., evaluator informed RN-E of immediate correction order issued due to the licensee's failure to ensure staff wore PPE per CDC and the MDH guidelines. On November 22, 2022, at 1:12 p.m., RN-E stated the licensee did not have a COVID-19 policy and procedure.	0 510		

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0 510	Continued From page 6 TIME PERIOD TO CORRECT: Two (2) Days ********** ********** An immediate order was identified due to the licensee's failure to ensure staff wore full personnel protective equipment (PPE) in COVID-19 positive resident rooms. The immediate order began on November 22, 2022, at 10:45 a.m., and immediacy was removed on November 22, 2022, at 5:05 p.m. noncompliance issues remained at scope and severity level of F, widespread-potential for harm.	0 510		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement individual abuse prevention plan (IAPP) that included an individualized assessment of the resident's susceptibility of self-abuse for one of	0 630		

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0 630	Continued From page 7 one resident (R1). This affected all other 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 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). Findings include: R1's diagnoses included angina (chest pain) and hypertension. R1's service plan dated for July 14, 2021. R1's care plan dated February 20, 2020, indicated R1 required assistance with bathing, medication administration, and food preparation. The same care plan indicated R1 required monitoring for dressing and eating. R1's assessment dated June 16, 2022, indicated R1 was alert to person and place. The same assessment did not indicate any current behaviors. R1's Assessment for Client Vulnerability and Safety dated June 16, 2022, did not include R1's susceptibility of self-abuse. R1's incident report dated July 4, 2022, indicated R1 cut open his window screen, jumped out the window, and staff called 911. R1's progress notes did not include entries from January 21, through July 4, 2022.	0 630		

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0 630	Continued From page 8 Daily communion logs dated July 1 through July 4, 2022, did not indicate any changes or updates with R1. R1's discharge summary dated July 4, 2022, indicated at 12:40 p.m., R1 cut through his window screen in his room, leapt through the window, and fell two stories to drain rocks below. Staff members were outside on break and seen R1 jump, yelled to call 911, and ran to R1. R1 was awake and talked while waiting for the ambulance to arrive. When asked why he jumped, R1 stated he was sick of living, and he was old enough. R1 transported to the hospital and passed away at approximately 4:00 p.m. R1's death record indicated cause of death was blunt abdominal trauma and descent from window. On November 22, 2022, at 4:12 p.m., registered nurse (RN)-E stated R1's IAPP did not include a review or assessment of R1's susceptibility of self-abuse and no other licensee residents IAPP's included a review or assessment. When asked if R1 was at risk, RN-E stated not that she or other licensee staff ever saw. RN-E stated R1 lived at the facility for three years. During his stay R1 did not make any statements to her or to other staff that he wanted to hurt or kill himself nor discuss any plans to do so. The licensee's policy titled "Vulnerable Adult Risk Assessment and Plan and Individual Abuse Prevention Plan" dated July 14, 2021, indicated each resident would be assessed for areas of vulnerability of being harmed or harming others. The same policy did not indicate the IAPP included an individualized review or assessment	0 630		

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0 630	Continued From page 9 of the resident's susceptibility of self-abuse and statements of the specific measures to be taken to minimize the risk. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for four of four residents (R1, R2, R3, R4) with records reviewed. This had the potential to affect all residents at the facility. 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).	0 910		

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0 910	Continued From page 10 Findings include: R1's Villa Court Senior Community Rental Contract dated for July 14, 2021. R2's Villa Court Senior Community Rental Contract dated for July 23, 2021. R3's Villa Court Senior Community Rental Contract dated for July 21, 2021. R4's Villa Court Senior Community Rental Contract dated for July 23, 2021, did not include R4 or representative signature. R1, R2, R3 and R4's contract lacked the following required content: - license number of the facility. On November 22, 2022, at 2:11 p.m., registered nurse (RN)-E stated the Villa Court Senior Community Rental Contract, the Villa Court Service Plan and Villa Court Senior Community Customized Living Plan, was the licensee's assisted living contract. RN-E stated this was what all residents received for a contract. The licensee's policy titled "Admission of A Resident" dated August 4, 2021, indicated the licensee's contract included a rental contract and service plan. The same policy did not indicate required content for contracts. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30721	A. BUILDING: _____ B. WING _____	C 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA VISTA AND CARDINAL COURT	1220 VILLA COURT DRIVE CROMWELL, MN 55726

(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
0 920	Continued From page 11 (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for four of four residents (R1, R2, R3, R4) with records reviewed. This had the potential to affect all residents at the facility. 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	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA VISTA AND CARDINAL COURT	1220 VILLA COURT DRIVE CROMWELL, MN 55726

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0 920	Continued From page 12 or has the potential to affect a large portion or all the residents). Findings include: R1's Villa Court Senior Community Rental Contract dated for July 14, 2021. R2's Villa Court Senior Community Rental Contract dated for July 23, 2021. R3's Villa Court Senior Community Rental Contract dated for July 21, 2021. R4's Villa Court Senior Community Rental Contract dated for July 23, 2021, did not include R4 or representative signature. R1, R2, R3 and R4's contract lacked the following required content: - disclosure of category of ALF license & disclosure if not licensed as an ALF dementia care On November 22, 2022, at 2:11 p.m., registered nurse (RN)-E stated the Villa Court Senior Community Rental Contract, the Villa Court Service Plan and Villa Court Senior Community Customized Living Plan, was the licensee's assisted living contract. RN-E stated this was what all residents received for a contract. The licensee's policy titled "Admission of A Resident" dated August 4, 2021, indicated the licensee's contract included a rental contract and service plan. The same policy did not indicate required content in contracts. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		

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VILLA VISTA AND CARDINAL COURT	1220 VILLA COURT DRIVE CROMWELL, MN 55726

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0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for four of four residents (R1, R2, R3, R4) with records reviewed. This had the potential to affect all resdients at the facility. 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	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VILLA VISTA AND CARDINAL COURT	1220 VILLA COURT DRIVE CROMWELL, MN 55726

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0 930	Continued From page 14 the residents). Findings include: R1's Villa Court Senior Community Rental Contract dated for July 14, 2021. R2's Villa Court Senior Community Rental Contract dated for July 23, 2021. R3's Villa Court Senior Community Rental Contract dated for July 21, 2021. R1, R2, R3 and R4's contract lacked the following required content: - the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent was required for a transfer -contact information for the Ombudsman for Mental Health & Developmental Disabilities, and Office of Heath Facility Complaints On November 22, 2022, at 2:11 p.m., registered nurse (RN)-E stated the Villa Court Senior Community Rental Contract, the Villa Court Service Plan and Villa Court Senior Community Customized Living Plan, was the licensee's assisted living contract. RN-E stated this was what all residents received for a contract. The licensee's policy titled "Admission of A Resident" dated August 4, 2021, indicated the licensee's contract included a rental contract and service plan. The same policy did not indicate required content for contracts. TIME PERIOD FOR CORRECTION: Twenty-one	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VILLA VISTA AND CARDINAL COURT	1220 VILLA COURT DRIVE CROMWELL, MN 55726

(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
0 930	Continued From page 15 (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 940	Continued From page 16 Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for four of four residents (R1, R2, R3, R4) with records reviewed. This had the potential to affect all residents at the facility. 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). Findings include: R1's Villa Court Senior Community Rental Contract dated for July 14, 2021. R2's Villa Court Senior Community Rental Contract dated for July 23, 2021. R3's Villa Court Senior Community Rental Contract dated for July 21, 2021. R4's Villa Court Senior Community Rental Contract dated for July 23, 2021, did not include R4 or representative signature. R1, R2, R3 and R4's contract lacked the following required content: - a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including:	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 940	Continued From page 17 - whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; - the contact information to obtain long-term care consulting services under section 256B.0911; and - the toll-free phone number for the Minnesota Adult Abuse Reporting Center. On November 22, 2022, at 2:11 p.m., registered nurse (RN)-E stated the Villa Court Senior Community Rental Contract, the Villa Court Service Plan and Villa Court Senior Community Customized Living Plan, was the licensee's assisted living contract. RN-E stated this was what all residents received for a contract.	0 940		

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0 940	Continued From page 18 The licensee's policy titled "Admission of A Resident" dated August 4, 2021, indicated the licensee's contract included a rental contract and service plan. The same policy did not indicate required content for contracts. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
0 950 SS=C	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 950	Continued From page 19 name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure four of four residents (R1, R2, R3. R4) contracts included a notice with the required veribage for the residents to identify a designated representative. This had the potential to affect all residents at the facility. 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). Findings include: R1's Villa Court Senior Community Rental Contract dated for July 14, 2021. R2's Villa Court Senior Community Rental Contract dated for July 23, 2021. R3's Villa Court Senior Community Rental Contract dated for July 21, 2021. R4's Villa Court Senior Community Rental Contract dated for July 23, 2021, did not include R4 or representative signature. R1, R2, R3 and R4's Villa Court Senior Community Rental Contract Signature Page indicated an area for the resident to designate a representative which included a named	0 950		

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0 950	Continued From page 20 designated representative, address, and phone number. R1, R2, R3, and R4's contract lacked evidence of a notice with the required statutory language for the resident to identify a designated representative or documentation that R2 declined to name a designated representative. On November 22, 2022, at 2:11 p.m., registered nurse (RN)-E stated the Villa Court Senior Community Rental Contract, the Villa Court Service Plan and Villa Court Senior Community Customized Living Plan, was the licensee's assisted living contract. RN-E stated this was what all residents received for a contract. The licensee's policy titled "Admission of A Resident" dated August 4, 2021, indicated the licensee's contract included a rental contract and service plan. The same policy did not indicate required content in contracts. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		