Electronically Delivered

August 25, 2022

Administrator
S&O's Assisted Living, LLC
14856 Edgewater Road Northeast
Pine City, MN 55063

RE: Project Number(s) SL36440015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 16, 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, no immediate fines are assessed.

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

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 St. Paul, MN 55164-0970

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,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36440	A. BUILDING: _____ B. WING _____	08/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
S&O'S ASSISTED LIVING LLC	14856 EDGEWATER ROAD NE PINE CITY, MN 55063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders have been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36440015-0 On August 15, 2022, through August 16, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were five residents receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 SUBDIVISION 1-3.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to two of two residents (R1, R2) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include:	0 430		

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0 430	Continued From page 2 R1 R1 admitted for assisted living services on January 10, 2022. R1's service plan dated January 10, 2022, indicated R1 received services including medication administration and assistance with bathing, grooming, toileting, bed mobility, transfers and dressing. R1's record lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. R2 R2 admitted for assisted living services on March 21, 2022. R2's Service Plan dated March 21, 2022, indicated R2 received services for medication management, personal cares, bathing, ambulation, toileting, orientation, transfers, meal assist, housekeeping and laundry. R2's record lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services	0 430		

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0 430	Continued From page 3 the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. On August 16, 2022, at approximately 11:30 a.m., licensed assisted living director (LALD)-A stated licensee had an older version of the UDALSA and was in the process of updating their assisted living documents prior to providing to residents. LALD-A confirmed R1, R2, and all other residents receiving services under the licensee's Assisted Living with Dementia Care License had not received the uniform checklist disclosure. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480		

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0 480	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all five 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 16, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to	0 580		

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0 580	Continued From page 5	0 580		

be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to maintain documentation of a quality management activity. This had the potential to affect all five residents receiving assisted living with dementia care services.

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

The findings include:

On August 15, 2022, at approximately 11:20 a.m., the surveyor requested documentation of the licensee's quality management activity. Licensed assisted living director (LALD)-A stated, "to be honest, we haven't had a meeting in a while, and I don't have that."

The licensee's Quality Management Plan policy dated January 2020, indicated the licensee would establish a quality improvement program with meetings held at least quarterly to identify and review dashboard and other quality measures, set goals, and identify needed changes in

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0 580	Continued From page 6 procedures or training for staff. Additionally, the policy indicated documentation of quality improvement activities would be retained in the agency files for two years and made available to the Minnesota Department of Health (MDH) upon request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at	0 650		

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0 650	Continued From page 7 least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee records contained the required content for two of two employees (unlicensed personnel (ULP)-C and ULP-D), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: ULP-C ULP-C had a hire date of April 21, 2020, and began providing services under the licensee's Assisted Living license on August 1, 2021. ULP-C's record lacked a 2022 annual performance review that identified areas of improvement needed and training needs. ULP-C's last annual performance review was completed February 22, 2021. ULP-D	0 650		

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0 650	Continued From page 8 ULP-D had a hire date of December 9, 2020, and began providing services under the licensee's Assisted Living license on August 1, 2021. ULP-D's record lacked a 2022 annual performance review that identified areas of improvement needed and training needs. ULP-D's last performance review was completed on March 15, 2021. On August 15, 2022, at approximately 2:43 p.m., licensed assisted living director (LALD)-A confirmed ULP-C and ULP-D employee records lacked an annual performance evaluation, as required and stated, "they are a little overdue." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding	0 680		

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0 680	Continued From page 9 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 interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content. This had the potential to affect all five residents receiving services under the assisted living with dementia care 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 15, 2022, at approximately 11:00 a.m., the surveyor requested to view the licensee's emergency preparedness plan, which was provided to and later reviewed by the surveyor. The licensee's emergency preparedness plan included emergency plans for a fire, severe	0 680		

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0 680	Continued From page 10 weather, power outage, bioterrorism, infectious disease, bomb threat, chemical spill, heat/humidity, and a procedure for apartment evacuation. The licensee's plan lacked the following content and/or policies and procedures to address: - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - the facility's role in providing care and treatment at alternative sites; - the provision of subsistence needs for staff and residents; - a tracking system used to document locations of residents and staff; - an evacuation plan; - how the facility would provide a means to shelter in place for residents and volunteers; - the medical record documentation system the facility has developed to preserve resident information security and availability of records; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. In addition, the licensee lacked a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the	0 680		

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0 680	Continued From page 11 facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the emergency plan with residents and their families. On August 16, 2022, at approximately 1:30 p.m., licensed assisted living director (LALD)-A confirmed the licensee had not fully developed and implemented the facility's emergency preparedness plan/program. LALD-A stated she thought she had all the requirements included when she [LALD-A] put together the facility emergency preparedness plan. The licensee's Emergency Preparedness policy dated January 2020, indicated the facility would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. Additionally, the policy indicated the LALD and registered nurse (RN) would be responsible for the development of a written plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used	0 780		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 12 for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain smoke alarms that are interconnected throughout the facility. This deficient condition had the ability to affect all staff and 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 potential to affect a large portion or all of the residents). Findings include: During the facility tour on August 15, 2022, at approximately 12:30 p.m. with the licensed	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36440	A. BUILDING: _____ B. WING _____	08/16/2022

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S&O'S ASSISTED LIVING LLC	14856 EDGEWATER ROAD NE PINE CITY, MN 55063

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0 780	Continued From page 13 administrator (LALD)-A, it was observed that the smoke alarms are outdated and not within 10 years of the date of manufacture. The hardwired and battery-operated smoke alarms in the bedrooms and hallways were manufactured in April of 2002. LALD-A verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 800		

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0 800	Continued From page 14 or has the potential to affect a large portion or all of the residents). The findings include: On August 15, 2022, between 12:00 p.m. and 2:30 p.m., survey staff toured the licensed administrator (LALD)-A. During the facility tour, survey staff observed the following: 1. The grab bar by room 2 and room 3 in the shower was not secured to the wall only the surround. 2. A towel bar was used as a grab bar by the toilet by room 3 and the bathroom by the salon. 3. The indoor/outdoor carpet on the ramp on the outside exit from the dining room has burn holes and missing boards. LALD-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810		

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0 810	Continued From page 15 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 810		

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0 810	Continued From page 16 a large portion or all of the residents). On August 15, 2022, between 12:00 p.m. and 2:30 p.m., the licensed administrator (LALD)-A failed to provide documents for review. 1. The licensee failed to provide employee training logs for fire safety and evacuation. 2. The licensee failed to provide the required employee training frequency. 3. The licensee failed to provide documentation of resident evacuation training. The LALD-A verbally confirmed survey staff observations during the facility tour. No additional information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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:	0 910		

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0 910	Continued From page 17 Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a written contract with the following required content: - the licensee of the facility; - the managing agent of the facility; and - HFID number. R1and R2's Service Plan Assisted Living Contract dated January 10, 2022, and March 21, 2022, respectively, lacked requirements noted above. On August 15, 2022, at approximately 3:30 p.m., licensed assisted living director (LALD)-A provided a compiled set of documents titled; Service Plan, Rental Agreement, Resident Handbook, Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers, Client Acknowledgment Form, Release of Information, Photographic Release, Personal Inventory Sheet, HCBS Rights for People Receiving Services and Comprehensive Home Care Provider Services. LALD-A confirmed the package of documents were considered by LALD-A to be the assisted living written contract. The compiled package of documents did not	0 910		

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0 910	Continued From page 18 meet assisted living contract requirements. LALD-A stated, "I am working on getting the new contract finished. No, I haven't gotten it out to our residents yet for them to sign." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (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	0 920		

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0 920	Continued From page 19 by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 and R2's contracts lacked the following: - 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; - 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; - a delineation of the cost and nature of any other services to be provided for an additional fee; - 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; - a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; and - disclosure of the facility's ability to provide specialized diets.	0 920		

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0 920	Continued From page 20 R1and R2's Service Plan Assisted Living Contract dated January 10, 2022, and March 21, 2022, respectively, lacked the requirements noted above and referenced comprehensive licensing throughout the documents. On August 15, 2022, at approximately 3:30 p.m., licensed assisted living director (LALD)-A provided a compiled set of documents titled; Service Plan, Rental Agreement, Resident Handbook, Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers, Client Acknowledgment Form, Release of Information, Photographic Release, Personal Inventory Sheet, HCBS Rights for People Receiving Services and Comprehensive Home Care Provider Services. LALD-A confirmed the package of documents were considered by LALD-A to be the assisted living written contract. The compiled package of documents did not meet assisted living contract requirements. LALD-A stated, "I am working on getting the new contract finished. No, I haven't gotten it out to our residents yet for them to sign." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
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	0 930		

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0 930	Continued From page 21 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 assisted living contract with all required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 and R2's assisted living contracts lacked the following content: - the right under section 144G.54 to appeal the termination of an assisted living contract; and - the facility's policy regarding transfer of residents within the facility, under what	0 930		

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0 930	Continued From page 22 circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer. R1and R2's Service Plan Assisted Living Contract dated January 10, 2022, and March 21, 2022, respectively, lacked the requirements noted above and referenced comprehensive licensing throughout the documents. On August 15, 2022, at approximately 3:30 p.m., licensed assisted living director (LALD)-A provided a compiled set of documents titled; Service Plan, Rental Agreement, Resident Handbook, Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers, Client Acknowledgment Form, Release of Information, Photographic Release, Personal Inventory Sheet, HCBS Rights for People Receiving Services and Comprehensive Home Care Provider Services. LALD-A confirmed the package of documents were considered by LALD-A to be the assisted living written contract. The compiled package of documents did not meet assisted living contract requirements. LALD-A stated, "I am working on getting the new contract finished. No, I haven't gotten it out to our residents yet for them to sign." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (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	0 940		

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0 940	Continued From page 23 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 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 two of two residents (R1, R2) with records reviewed.	0 940		

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0 940	Continued From page 24 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 and R2's Service Plan Assisted Living Contract lacked the following 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: (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; (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. On August 15, 2022, at approximately 3:30 p.m., licensed assisted living director (LALD)-A	0 940		

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0 940	Continued From page 25 provided a compiled set of documents titled; Service Plan, Rental Agreement, Resident Handbook, Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers, Client Acknowledgment Form, Release of Information, Photographic Release, Personal Inventory Sheet, HCBS Rights for People Receiving Services and Comprehensive Home Care Provider Services. LALD-A confirmed the package of documents were considered by LALD-A to be the assisted living written contract. The compiled package of documents did not meet assisted living contract requirements. LALD-A stated, "I am working on getting the new contract finished. No, I haven't gotten it out to our residents yet for them to sign." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
0 970 SS=F	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: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the	0 970		

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0 970	Continued From page 26 facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 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), 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 and R2's Service Agreement Assisted Living contract dated January 10, 2022, and March 21, 2022, respectively, contained a paragraph clause indicating the resident would waive the facility's liability as follows: "[facility name] is not responsible for lost, stolen or damaged property. If you have anything of value, we encourage you to leave it with family members or a safe deposit box". Page 9, Item K under heading Welcome and Introduction. On August 16, 2022, at approximately 3:40 p.m., licensed assisted living director (LALD)-A confirmed R1 and R2's contracts included the waiver of liability, and said the same assisted living service agreement was used for all residents at the facility. No further information available. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		

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01060	Continued From page 27	01060		
01060 SS=E	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's	01060		

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01060	Continued From page 28 refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to notify the Office of Ombudsman for Long-Term Care of resident relocation within four days for two of two residents (R4, R5) 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: The licensee's Resident Roster identified R4's date of admission was July 14, 2022, and date of emergency transfer to a local hospital for evaluation was July 30, 2022. R4's Nurse Progress Note dated July 30, 2022, indicated R4 was reported by staff as "irritable with staff, refusing to allow cares, not wanting to get up". Unlicensed personnel (ULP) documented R4 was "incontinent of a large amount of urine and stool with a lot of blood and clotting noted by staff." Clinical nurse supervisor (CNS)-B instructed ULP's to immediately send R4 to the emergency room for evaluation. At approximately 10:15 p.m., licensee was notified by the hospital	01060		

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01060	Continued From page 29 nursing staff that R4 was being transferred to a large specialty hospital. As of August 16, 2022, during the on-site survey, R4 had not returned to licensee. On August 16, 2022, at approximately 9:30 a.m., LALD-A stated R4 had been transferred to a rehabilitation facility. The licensee's Resident Roster identified R5's date of admission was April 21, 2020, and date of transfer to the emergency room for evaluation was June 21, 2022. R5's Nurse Progress Note dated June 21, 2022, indicated R5 had an "unwitnessed fall in her room and had apparent injury to her right ankle." On June 27, 2022, CNS-B documented into nursing notes, "resident will be transferred to a transitional care unit (TCU) as we are unable to take her back due to needing a Hoyer (an assistive medical device used to lift individuals requiring 90-100% of assistance to move). Anticipate six to eight weeks at TCU." On August 16, 2022, at approximately 9:30 a.m., LALD-A responded, "No, are we supposed to do that?" to having notified the Office of Ombudsman for Long-Term Care of R4 and R5's relocation and after they had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	01620		

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01620	Continued From page 30	01620		

be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.
(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

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) completed a comprehensive smoking assessment for one of one resident (R2) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the

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01620	Continued From page 31 situation has occurred only occasionally). The findings include: On August 15, 2022, at approximately 10:45 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated assessments were completed upon admission, at day 14, every 90 days and with any significant change in condition. R2's diagnoses included stroke with dominant right sided deficiencies, seizures and memory loss. R2's Service Plan dated March 21, 2022, indicated R2 received services including medication management, ambulation, bathing, dressing, grooming, toileting, meal assistance, housekeeping and laundry. On August 15, 2022, at approximately 12:08 p.m., the surveyor observed R2 sitting in her manually operated wheelchair in an outdoor patio area smoking unattended. At 12:18 p.m., the surveyor observed unlicensed personnel (ULP)-D enter the patio area and assist R2 back into the building. At 1:43 p.m., the surveyor observed R2 outside the main entry doors smoking unattended and was assisted back into the building by ULP-C. ULP-D stated R2 will press her call pendant when she [R2] is ready to come back into the building. R2's 90-day Baseline Nursing Assessment/ Re-assessment dated June 30, 2022, indicated R2 had a history of seizures, right sided deficiencies and memory loss. The assessment indicated R2 had a history of smoking and continued to smoke five cigarettes per day. R2's record lacked a smoking assessment to	01620		

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01620	Continued From page 32 include R2's ability to safely smoke unattended without causing burns or injury to self or others or damage to the property which is a required component of the Uniform Assessment Tool under Minnesota Administrative Rule 4659.0150 Subp. 2. (M) (8). On August 15, 2022, at approximately 3:40 p.m., clinical nurse supervisor (CNS)-B verified R2 did not have a smoking assessment completed. The licensee's Initial and On-going Nursing Assessment of Residents Under the Comprehensive Licensed Agency (licensee held an assisted living with dementia license), dated January 2020, indicated the RN would complete a comprehensive nursing assessment of the resident's physical, mental, and cognitive needs as required, which would have included a smoking assessment for a resident with cognitive changes that smokes and resides in an assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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 33 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 all required content for two of two residents (R2, R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01650		

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01650	Continued From page 34 R2 R2's diagnoses included chronic pain, stroke affection right dominant side, seizures and major depressive disorder. R2's Service Plan dated March 21, 2022, indicated R2 received services for medication management, personal cares, bathing, ambulation, toileting, orientation, transfers, meal assist, housekeeping and laundry. On August 16, 2022, at approximately 7:52 a.m., the surveyor observed unlicensed personnel (ULP)-D assist R2 with medication administration. R2's service plan lacked the following required content: - a description of the services to be provided, and the frequency of each service, according to the resident's current assessment and resident preferences; - the identification of staff or categories of staff who will provide the services; - the methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; (iii) the name 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.	01650		

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01650	Continued From page 35 R2's Scheduled Services dated August 2022, included the following completed services signed off by unlicensed personnel and licensed nursing staff: - daily activity per activity calendar; - three meals and two snacks offered each day; - light housekeeping done twice daily, empty trash, make bed, laundry away; - shower one time weekly and as needed; - dusting and vacuum Monday, laundry one time weekly and as needed; - nail care; - monitor bowel movements one time per shift; - two-hour safety checks; - peri-care, oral cares am and pm; and - monthly vitals. R1 R1's diagnoses included dementia, stroke affecting right side and glaucoma. R1's service plan dated January 10, 2022, indicated R1 received services including medication administration and assistance with bathing, grooming, toileting, bed mobility, transfers and dressing. On August 16, 2022, at approximately 9:02 a.m., the surveyor observed ULP-C assist R1 with medication administration. R1's service plan lacked the following required content: - a description of the services to be provided, and the frequency of each service, according to the resident's current assessment and resident preferences; - the identification of staff or categories of staff who will provide the services; - the methods of monitoring assessments of the	01650		

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01650	Continued From page 36 resident; - the schedule and methods of monitoring staff providing services; (iii) the name 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. R1's Scheduled Services dated August 2022, included the following completed services signed off by unlicensed personnel and licensed nursing staff: - daily activity per activity calendar; - three meals and two snacks offered each day; - light housekeeping done twice daily, empty trash, make bed, laundry away; - shower one time weekly and as needed; - dusting and vacuum Monday, laundry one time weekly and as needed; - nail care; - monitor bowel movements one time per shift; - two-hour safety checks; - peri-care, oral cares am and pm; - monthly vitals; and - rinse and lay out nebulizer parts after each use. On August 16, 2022, at approximately 11:20 a.m., licensed assisted living director (LALD)-A confirmed the service plan did not list the tasks being performed for managing and monitoring R1 and R2's individual needs. Additionally, LALD-A stated all resident service plans were set up the	01650		

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01650	Continued From page 37 same way. The licensee's Contents of Service Plans policy dated January 2020, indicated all service plans would include a description of services provided, frequency of each service, fees for services, identification of staff or category of staff that would provide the service, schedule and method of monitoring assessments, the schedule and method of monitoring staff providing services and a contingency plan that contained the missing above noted items. Additionally, the policy indicated service plans were reviewed and revised by the registered nurse (RN) as needed based upon ongoing resident assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	01730		

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01730	Continued From page 38 directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of two residents (R2, R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01730		

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cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

During the entrance conference on August 15, 2022, at approximately 10:15 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided medication management services to the residents in the facility.

R2
R2's diagnoses included chronic pain, stroke affection right dominant side, seizures and major depressive disorder.

R2's Service Plan dated March 21, 2022, indicated R2 received services for medication management, personal cares, bathing, ambulation, toileting, orientation, transfers, meal assist, housekeeping and laundry.

R2's Medication Sheet dated August 2022 included: two antiseizure, one stool softener, one antidepressant, one antianxiety, one estrogen replacement, one anticonstipation, one allergy med and one narcotic pain medication.

On August 16, 2022, at approximately 7:52 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 with medication administration.

R2's medication management record did not include the following:
- identification of medication management tasks that may be delegated to unlicensed personnel;

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and
- documentation of specific resident instructions relating to the administration of medications.

R1
R1's diagnoses included dementia, stroke affecting right side and glaucoma.

R1's service plan dated January 10, 2022, indicated R1 received services including medication administration and assistance with bathing, grooming, toileting, bed mobility, transfers and dressing.

R1's Medication Administration Record dated August 2022 included: one mild pain reliever, one eye drop, one blood pressure reducer, one as needed (PRN) nebulizer inhalant and two skin ointments.

On August 16, 2022, at approximately 9:02 a.m., the surveyor observed ULP-C assist R1 with medication administration.

R1's medication management record did not include the following:
- identification of medication management tasks that may be delegated to unlicensed personnel; and
- documentation of specific resident instructions relating to the administration of medications.

On August 16, 2022, at approximately 11:20 a.m., licensed assisted living director (LALD)-A confirmed R1 and R2's individualized medication management record lacked all required content noted above.

The licensee's policy Development of the Individualized Medication Management Plan

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S&O'S ASSISTED LIVING LLC	14856 EDGEWATER ROAD NE PINE CITY, MN 55063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 41 (IMMP) and Individualized Medication Administration Record (MAR) dated January 2020 indicated an individualized medication management plan would be developed for each resident and would be a part of the service plan. Additionally, the policy indicated after the registered nurse (RN) has developed the individual medication management plan, the RN would develop a medication administration record with detailed information about the medications staff would be managing. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure as needed (PRN)	01760		

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01760	Continued From page 42 medications had documentation of effectiveness after administration for one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: PRN EFFECTIVENESS R2 was admitted for services on March 21, 2022. R2's diagnoses included stroke with dominant right-side deficiencies. R2's service plan dated March 21, 2022, indicated R2 received medication administration two times daily and PRN. R2's PRN Medication Record for August 2022, indicated: - on August 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 2022, R2 received Oxycodone 5 milligram (mg) by mouth every six hours as needed for pain; and - on August 3, 4, 6, 9, 10, 11, 13, 14, 2022, R2 received Benadryl 50 mg by mouth twice daily PRN for allergy symptoms; - on August 1, 7, 12, 15, 2022, R2 received Tylenol 325 mg two tabs by mouth every four hours PRN for pain.	01760		

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01760	Continued From page 43 R2's PRN medication record lacked documentation of the effectiveness of the PRNs given. On August 16, 2022, at approximately 11:20 a.m., licensed assisted living director (LALD)-A confirmed R2's medication record lacked follow up documentation of administered PRN's and stated the expectation for ULP's when administering as needed medications was they should document the effectiveness of the medication in the MAR. The licensee's Administration and Documentation of PRN Medication policy dated January 2020, indicated staff would administer PRN medications exactly as prescribed and would document administration of PRNs on the form required by the registered nurse (RN). Licensee's PRN policy did not address documentation of a follow up for effectiveness. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by:	01770		

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01770	Continued From page 44 Based on observation, interview and record review, the license failed to ensure documentation of medication setup was completed at the time of setup and included all the required content for one of one resident (R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 15, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-A stated to her knowledge there were no medication caddie (a pill container separated into compartments by days and times of the week) setups for residents. R6 R6's diagnoses included dementia, hypertension and diabetes. R6's service plan dated June 20, 2022, indicated R6 received services including medication administration. R6's prescriber orders provided to the surveyor were obtained by licensee after entrance on August 15, 2022, and included the following medications: - metformin 1000 milligrams (mg) twice daily; - metoprolol succinate extended release (ER) 50	01770		

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01770	Continued From page 45 mg daily; - multivitamin daily; - Crestor 5 mg daily; - lisinopril 40 mg daily; - Flomax 0.4 mg daily; - glipizide 10 mg twice daily; - Aricept 5 mg daily at bedtime; - Seroquel 25 mg daily at bedtime; - Senna 8.6 mg daily as needed (PRN); - Volaren 2 grams (G) up to four times daily PRN; and - Risperdal 0.25 mg twice daily PRN. On August 16, 2022, at approximately 12:00 p.m., the surveyor observed unlicensed personnel (ULP)-C check a blood glucose (sugar) level for R6. ULP-C completed the glucose check and returned to the medication cart to document the results. While ULP-C documented the results, the surveyor observed handwritten notes next to several medications listed on the medication record that read "set up by RN". The surveyor asked ULP-C what the handwritten notes referenced and ULP-C stated some of R6's medications were administered from a medication caddie. The surveyor observed the medication caddie with ULP-C which had a handwritten label on the underside with medication names and doses. The handwritten label did not contain a pill description. ULP-C stated, "we count them as we take them out". On August 16, 2022, at approximately 12:15 p.m., the surveyor requested medication caddie setup documentation for R6. Licensed assisted living director (LALD)-A confirmed R6's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration	01770		

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01770	Continued From page 46 and stated, "there isn't anything documented for when the nurse sets that up." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must	01940		

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01940	Continued From page 47 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop individual treatment management plans with all required content for one of two residents (R1) who received ordered treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included dementia, stroke affecting right side and glaucoma. R1's RN Assessment dated January 25, 2022, indicated R1 received services including supplemental oxygen via concentrator or tank via nasal cannula as needed (PRN). The assessment did not specify liters per minute (lpm). R1's provider orders dated August 2, 2022, ordered oxygen 1 to 4 liters per minute (lpm) apply via nasal cannula PRN. On August 16, 2022, at approximately 10:53 a.m., the surveyor observed unlicensed personnel (ULP)-D assist R1 with application of	01940		

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01940	Continued From page 48 supplemental oxygen via nasal cannula at 2 lpm. R1's record lacked an Individualized Treatment and Therapy plan to include the following: - a statement of the type of services that would be provided; - documentation of specific resident instructions relating to the treatment or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and - any resident-specific requirements related to documentation of treatment and therapy was received, verification all treatment and therapy was administered as prescribed, and monitoring occurred to prevent possible complications or adverse reactions. On August 16, 2022, at approximately 11:50 a.m., licensed assisted living director (LALD)-A confirmed R1 lacked an Individualized Treatment and Therapy Plan to include above noted content. The licensee's Development of the Individualized Treatment and Therapy Plan (ITTP) and Individualized Treatment Administration Record (TAR) policy dated January 2020, indicated following completion of the nursing assessment, including the need for treatment or therapy management, the registered nurse (RN) would develop an individualized treatment and therapy plan for the resident receiving management. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01940		

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01940	Continued From page 49 days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. Mitigation of property hazards to protect residents from harm was not included. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 15, 2022, at approximately 2:00 p.m., the licensed administrator (LALD)-A confirmed	02040		

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02040	Continued From page 50 during the exit interview that the facility failed to include safety risks or hazards identified on and around the property in the assessment. They also confirmed that mitigation of property hazards to protect residents from harm had not been completed. The HVA Dementia Care Tool 2022 was not provided and could not be verified for hazards or safety risks identified on and around the property with mitigation of property hazards to protect residents from harm. The LALD-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person overseeing staff training in the care of individuals	02140		

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02140	Continued From page 51 with dementia had documented evidence of competency, or a knowledge test required by the commissioner. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 15, 2022, at approximately 11:20 a.m., clinical nurse supervisor (CNS)-B stated she was the person in charge of overseeing the dementia care training for staff. CNS-B stated she completed "EduCare" (computer-based training) modules related to care of residents with dementia, and she was not allowed to work with the residents until the training had been completed. CNS-B's training transcript indicated she had completed the requisite number of required hours in dementia care. However, CNS-B's record lacked evidence CNS-B had demonstrated competency to be the person in charge of overseeing staff training. On August 16, 2022, at approximately 2:15 p.m., licensed assisted living director (LALD)-A stated she had course transcripts as dementia training records which listed the courses completed. LALD-A confirmed CNS-B had not completed a competency test for the courses and stated, "I	02140		

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02140	Continued From page 52 wasn't aware she needed to do that." The licensee lacked a policy related to dementia training and the requirements of the trainer. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those	02170		

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02170	Continued From page 53	02170		

that may help defuse a behavior;
(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;
(5) spiritual, creative, and intellectual activities;
(6) sensory stimulation activities;
(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and
(8) outdoor activities.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to have an evaluation for an activity plan for two of two residents (R1, R2) who resided in the dementia-care licensed facility.

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

The findings include:

During the entrance conference on August 15, 2022, at approximately 10:30 a.m., licensed assisted living director (LALD)-A stated they were licensed as an assisted living facility with dementia care and provided dementia care services.

R1
R1's diagnoses included dementia, stroke affecting right side and glaucoma.

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02170	Continued From page 54 R1's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R1's record lacked the development of an individualized activity plan. R2 R2's diagnoses included chronic pain, stroke affection right dominant side, seizures and major depressive disorder. R2's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R2's record lacked the development of an individualized activity plan. On August 16, 2022, at approximately 11:45 a.m., licensed assisted living director (LALD)-A confirmed activity evaluations were not completed	02170		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
S&O'S ASSISTED LIVING LLC	14856 EDGEWATER ROAD NE PINE CITY, MN 55063

(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
02170	Continued From page 55 for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: *08/16/22*
Time: 11:30:00
Report: 1016221128

Food and Beverage Establishment Inspection Report

Location:
S&O'S Assisted Living Llc
14856 Edgewater Road Ne
Pine City, MN55063
Pine County, 58

Establishment Info:
ID #: 0037990
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3206291447
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13A ** Priority 2 **

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

A TEMPERATURE MEASURING DEVICE WAS NOT AVAILABLE TO MEASURE THE TEMPERATURE OF THE DISH WASHER. OBTAIN A TEMPERATURE MEASURING DEVICE FOR MONITORING THE DISH WASHER.

Comply By: 08/19/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

Randi HAD A VALID FOOD SAFETY CERTIFICATE, BUT HAD NOT OBTAINED A CFPM CERTIFICATE. RENEW FOOD SAFETY CERTIFICATE AND OBTAIN CFPM CERTIFICATE.

Comply By: 09/30/22

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: CELERY
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: EGGS
Violation Issued: No

Type: Full
Date: *08/16/22*
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S&O'S Assisted Living Llc

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: ONIONS
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

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

COMMENTS:

DISCUSSED REQUIREMENT FOR SAME DAY CONSUMPTION OF FOOD WITH STAFF.

A LINK TO INFORMATION ON HOW TO OBTAIN CFPM CERTIFICATE WILL BE INCLUDED IN EMAIL TO Randi.

SANITIZER AND TEST STRIP WERE AVAILABLE BUT NOT MIXED FOR TESTING AT TIME OF INSPECTION.

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1016221128 of 08/16/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____

Randi
KITCHEN MANAGER

Signed:_____

Cliff LaVigne
Sanitarian
Duluth
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clifford.lavigne@state.mn.us