DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

January 4, 2023

Licensee
Ma's Room And Board
605 East Avenue
Red Wing, MN 55066

RE: Project Number(s) SL32641015

Dear Licensee:

On December 23, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the October 28, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

PMB

Electronically Delivered

November 30, 2022

Administrator
Ma's Room And Board
605 East Avenue
Red Wing, MN 55066

RE: Project Number(s) SL32641015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 28, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2,

9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division

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

Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 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
	32641	A. BUILDING: _____ B. WING _____	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32641015 On October 25, 2022, through October 28, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 10 residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.	
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet	0 470		

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0 470	Continued From page 1 the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure night staff were awake to monitor residents needs and to minimize the risk of self-abuse. This had the potential to affect all 10 residents residing in the facility. This practice resulted in a level three violation (a violation that harmed a residents health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 470		

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0 470	Continued From page 2 The findings include: During an interview with resident (R)2 on October 25, 2022, at 10:15 a.m., R2 stated that unlicensed personnel (ULP)-E would sleep when she worked the 6:00 p.m. to 6:00 a.m. overnight shift. R2 stated ULP-E would clean the house until 10:00 p.m., and then would go to sleep. R2 stated ULP-E had small children and worked another job during the day so she would need to sleep when she would work. R2's Individual Abuse Prevention Plan dated May 2, 2022, indicated R2 did not have feeling in the bottom of his feet and needed staff monitoring to ensure R2 used a walker or cane when ambulating to prevent falls. During an interview on October 25, 2022, at 10:15 a.m., R3 stated that if they needed anything they would just pull their call cord and it would wake ULP-E up. R3's Uniform Assessment Tool dated August 1, 2022, indicated R3's elopement risk was high. During an interview on October 25, 2022, at 10:45 a.m., licensed assisted living director (LALD)-C stated ULP-E had been a long-term employee but had to resign because she would no longer be able to sleep when she worked for licensee. LALD-C stated they only utilized ULP-E when there was no other option to have another staff member work the overnight shift. LALD-C stated he was aware that ULP-E slept when she was working. LALD-C stated he felt there was no other option as there needed to be a staff member present on the overnight shift.	0 470		

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0 470	Continued From page 3 The licensee's 4.06 Staffing and Scheduling policy dated August 1, 2021, indicated the clinical nurse supervisor must ensure staffing levels are adequate to address resident needs twenty-four hours per day. No further information was provided. TIME PERIOD OF CORRECTION: IMMEDIATE The immediacy of the order was removed on October 27, 2022. This was confirmed and approved by evaluation supervisor.	0 470		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the current assisted living license at the main entrance of the assisted living building. 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:	0 570		

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0 570	Continued From page 4 During an observation on October 25, 2022, at approximately 10:45 a.m., the original current assisted living license was not posted at facility entrances, hallways, dining area, or in living areas. The licensee had posted the current assisted living license in the staff office which remained locked when staff were not present. On October 25, 2022, at approximately 10:55 a.m., licensed assisted living director (LALD)-C stated there was a current assisted living license dated August 1, 2022, displayed in the licensee's office. LALD-C stated he was not aware the license needed to be posted at the front entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by:	0 580		

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0 580	Continued From page 5 Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During an interview on October 25, 2022, at 10:55 a.m., licensed assisted living director (LALD)-C stated he conducted monthly staff meeting but did not specifically include topics of goal setting or quality management in his meetings. LALD-C stated that there was no documentation regarding the monthly meetings conducted by LALD-C. The licensee's 2.31 Quality Management Project policy dated August 1, 2021, indicated the licensee would have at least one documented quality management project in place at all times, and retain records of such projects for at least two years No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		

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0 660	Continued From page 6	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a facility TB risk assessment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 660		

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0 660	Continued From page 7 During the entrance conference on October 20, 2022, at approximately 10:40 a.m., with licensed assisted living director (LALD)-C, the surveyor requested to review the facility TB risk assessment. LALD-C stated a facility TB risk assessment was completed but would need to look for a copy of the form. On October 20, 2022, at approximately 1:25 p.m., LALD-C stated to the surveyor that he could not find a current TB risk assessment for licensee. LALD-C stated he was positive there had been a completed TB risk assessment but after looking, he could not find one. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated the licensee would maintain a current community TB risk assessment and the assessment would be updated annually. The Minnesota Department of Health (MDH) guidelines, Regulations for TB Control in Minnesota Health Care Settings dated June 10, 2019, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment performed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 770 SS=F	144G.45 Subdivision 1 Minimum site Requirements The following are required for all assisted living facilities:	0 770		

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0 770	Continued From page 8 (1) public utilities must be available, and working or inspected and approved water and septic systems must be in place; (2) the location must be publicly accessible to fire department services and emergency medical services; (3) the location's topography must provide sufficient natural drainage and is not subject to flooding; (4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and (5) the location must include space for outdoor activities for residents. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain the facility in baseline requirements, such that the facility location was readily accessible to fire and other emergency services. This deficient condition has 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: On 10/25/2022 between 1:00 PM to 2:00 PM, survey staff observed in the process of trying to locate the physical location of the facility, that there were not address numbers affixed to the	0 770		

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0 770	Continued From page 9 structure at the time of survey LALD verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 770		
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 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 staff interview, the	0 780		

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0 780	Continued From page 10 facility failed to maintain the facility fire protection and physical environment, such that the facility early detection devices and fire alarm system were in a state of confirmable readiness and repair. This deficient condition has the ability to affect all staff and residents. Findings include: 1. On 10/25/2022 between 1:00 PM to 2:00 PM, survey staff observed during the walkthrough of the facility and during documentation review that the age of the smoke alarms located in resident rooms could not be determined or identified. 2. On 10/25/2022 between 1:00 PM to 2:00 PM, survey staff observed during the walkthrough of the facility that the manual fire alarm pull-stations were missing the glass safety rods. LALD verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire	0 790		

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MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 790	Continued From page 11 Code; and This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain the facility fire extinguisher in accordance to standards. This deficient condition has the ability to affect all staff and residents. Findings include: On 10/25/2022 between 1:00 PM to 2:00 PM, survey staff observed during the walkthrough of the facility that a fire extinguisher was found to be freestanding on the floor outside of resident room (D.S.) on the second floor of the structure LALD verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
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 staff interview, the	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32641	A. BUILDING: _____ B. WING _____	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MA'S ROOM AND BOARD	605 EAST AVENUE RED WING, MN 55066

(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
0 800	Continued From page 12	0 800		

facility failed to maintain the facility in good repair in regards to resident health and safety in accordance with maintenance and repair program. This deficient condition has 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:

1. On 10/25/2022 between 1:00 PM to 2:00 PM, survey staff observed during the walk-through of the structure that resident room (R.H.) had excessive storage of combustibles

2. On 10/25/2022 between 1:00 PM to 2:00 PM, survey staff observed during the walk-through of the structure that resident room (R.H.) had extension cords in use, and that resident room (K.R.) had an electric multi-tap adapter connected to a power strip

3. On 10/25/2022 between 1:00 PM to 2:00 PM, survey staff observed during the walk-through of the structure that C.O. detectors were not located within 10 feet of resident rooms

4. On 10/25/2022 between 1:00 PM to 2:00 PM, survey staff observed during the walk-through of the structure that in resident room (C.T.) the egress window was access obstructed by furniture placement

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0 800	Continued From page 13 5. On 10/25/2022 between 1:00 PM to 2:00 PM, survey staff observed during the walk-through of the structure that the facility has a fire sprinkler system, but during documentation review no documents were presented to confirm that the system is operational, being inspected and maintained. 6. On 10/25/2022 between 1:00 PM to 2:00 PM, survey staff observed during the walk-through of the structure that fire sprinkler heads on the 2d FL, Main FL and basement exhibited signs of paint on heads, dust and debris. 7. On 10/25/2022 between 1:00 PM to 2:00 PM, survey staff observed during the walk-through of the structure that exit sign devices having illumination capability were not illuminated. LALD verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:	01730		

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01730	Continued From page 14 (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management record with the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a	01730		

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01730	Continued From page 15	01730		

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:

R1
R1 was admitted to the licensee on May 2, 2017. R1's diagnoses included mild mental retardation.

R1's signed service plan dated August 1, 2022, indicated R1 received medication management services.

R1's record lacked an individualized medication management plan.

R2
R2 was admitted to licensee on March 4, 2021. R2's diagnoses included diabetes and anxiety.

R2's signed service plan dated August 1, 2022, indicated R2 received medication management assistance.

R2's record lacked an individualized medication management plan.

During an interview on October 25, 2022, at 2:30 p.m., registered nurse (RN)-A stated she completed a medication assessment at the time of admission and as needed and thought this was considered the medication management plan.

The licensee's 7.03 Medication Management

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01730	Continued From page 16 Individualized Plan policy, dated August 1, 2021, indicated licensee would develop and maintain a current individualized medication management record for each resident based on the resident assessment. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01730		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entry way of the licensee's facility to display statutory language to disclose electronic monitoring activity. 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).	03090		

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03090	Continued From page 17 The findings include: On October 25, 2022, at 10:00 a.m., during a tour of the facility, the surveyor observed no electronic monitoring notice posted at the entrance to the licensee's facility. On October 25, 2022, 10:32 a.m., house manager (HM)-B acknowledged the licensee failed to post the required electronic monitoring notice. HM-B indicated no cameras were utilized by licensee. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul
651-201-4500

Type: Full
Date: *10/26/22*
Time: 10:09:01
Report: 7962221212

Food and Beverage Establishment Inspection Report

Location:
Ma'S Room And Board
605 East Avenue
Red Wing, MN55066
Goodhue County, 25

Establishment Info:
ID #: 0038934
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513989709
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 50ppm at Degrees Fahrenheit
Location: wiping cloth bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Domestic Refrigerator
Temperature: 39 Degrees Fahrenheit - Location: sour cream
Violation Issued: No

Process/Item: Domestic Refrigerator
Temperature: 39 Degrees Fahrenheit - Location: gallon milk
Violation Issued: No

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

Establishment Info:
Email reports to:
John Royalty, Owner, john@royaltyhomesinc.com
Sherri Vanberg, General Manager, sherri@royaltyhomesinc.com

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 7962221212 of 10/26/22.

Certified Food Protection Manager: Sherri Vanberg

Certification Number: FM49738 Expires: 04/07/24

Inspection report reviewed with person in charge and emailed.

Signed:_____
Sherri Vanberg
General Manager

Signed: Heather Flueger
Heather Flueger
Public Health Sanitarian
Rochester District Office
507-208-3096
heather.flueger@state.mn.us