Electronically delivered

May 4, 2022

Administrator
Robland Home Health Care
963 21st Street Southeast
Rochester, MN 55904

RE: Project Number(s) SL34623015

Dear Administrator:

On April 22, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on February 2, 2022. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the February 2, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on February 2, 2022, found not corrected at the time of the April 22, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

2040-Fire Protection And Physical Environment-144g.81 Subdivision 1 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on April 22, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

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.

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at (651) 201-3993.

Please note, 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.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 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
	34623	A. BUILDING: _____ B. WING _____	R 04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBLAND HOME HEALTH CARE	963 21ST STREET SE ROCHESTER, MN 55904

(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 this correction order(s) has 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: Project # SL34623015-2 On April 20, through April 22, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on February 2, 2022. At the time of the survey, there were 2 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment	{02040}		

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ROBLAND HOME HEALTH CARE	963 21ST STREET SE ROCHESTER, MN 55904

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{02040}	Continued From page 1 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 interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly 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) 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 residents). The findings include: A review of the Hazard Vulnerability Assessment showed global issues such as fire, gas leaks, and epidemics had been identified. Local hazards that are site, building, and population-specific had not been developed. During an interview on April 22, 2022, at 10:00 a.m., the licensed assisted living director	{02040}		

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ROBLAND HOME HEALTH CARE	**963 21ST STREET SE ROCHESTER, MN 55904**

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{02040}	Continued From page 2 (LALD)-A stated he had not completed the hazard vulnerability assessment on and around the facility property. No further information was provided.	{02040}		

Electronically Delivered

February 23, 2022

Administrator
Robland Home Health Care
963 21st Street Southeast
Rochester, MN 55904

RE: Project Number(s) SL34623015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on February 2, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. 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:	Free from Maltreatment reconsideration requests should addressed to:

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBLAND HOME HEALTH CARE	963 21ST STREET SE ROCHESTER, MN 55904

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#34623015 On January 31, 2022, through February 2, 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 two (2) residents receiving services under the provider's 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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD-A) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: LALD-A started employment on January 1, 2020, under the licensee's comprehensive home care license and began providing assisted living services on August 1, 2021. During the entrance conference on January 31, 2022, at approximately 9:56 a.m. LALD-A provided his license for assisted living director, which had an expiration date of October 31, 2022. On January 31, 2022, at approximately 12:37 p.m. the Minnesota Board of Executives for Long-Term Services and Support (BELTSS)	0 110		

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0 110	Continued From page 2 website indicated LALD-A currently held a LALD license, but LALD-A was not listed as the Director of Record for the licensee. The licensee policy Assisted Living Director dated August 1, 2021, indicated the licensee was required to have an Assisted Living Director licensed or permitted by the Board of Executives for Long Term Services and Supports (BELTSS) and the Assisted Living Director on record was responsible for the licensed Assisted Living and all operations within the setting. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in	0 250		

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0 250	Continued From page 3 any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and	0 250		

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0 250	Continued From page 4 implemented current policies and procedures, as required, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 31, 2022, at approximately 9:56 a.m. licensed assisted living director (LALD-A) stated he was familiar with the Assisted Living licensing laws and rules. The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable.	0 250		

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0 250	Continued From page 5 - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - In understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data (opens in a new window), the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets the requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in the application may, in some circumstances, be disclosed to the appropriate state, federal or local agency, and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent,	0 250		

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0 250	Continued From page 6 I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable. Page five was electronically signed by LALD-A on May 18, 2021. The licensee had an Assisted Living Dementia Care license, issued on August 1, 2021. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - infection control practices; - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff; - conducting initial and ongoing resident evaluations and assessments of resident needs,	0 250		

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	34623	A. BUILDING: _____ B. WING _____	02/02/2022

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0 250	Continued From page 7 including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; - orientation to and implementation of the assisted living bill of rights; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; and - supervision of unlicensed personnel performing delegated tasks. Refer to licensing order at Statute 144G.41, Subd. 3. The licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This had the potential to affect all residents, staff and visitors. Refer to licensing order at Statute 144G.42, Subd 6 (b). The licensee failed to develop and implement an individual abuse prevention plan that included statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults for identified vulnerabilities for one of one resident (R1) with record reviewed. Refer to licensing order at Statute 144G.42, Subd 8. The licensee failed to ensure employee records included all required content for one of two unlicensed personnel (ULP)-C with records reviewed.	0 250		

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0 250	Continued From page 8 Refer to licensing order at Statute 144G.42, Subd. 9. The licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines. This had the potential to affect all residents, staff and visitors. Refer to licensing order at Statute 144G.61., Subd. 2. The licensee failed to ensure training and competency evaluations contained all the required training for two of two unlicensed personnel (ULP-C, ULP-D) with records reviewed. Refer to licensing order at Statute 144G.62., Subd. 4. The licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the facility for one of two unlicensed personnel (ULP)-D with records reviewed. Refer to licensing order at Statute 144G.63, Subd. 2. The licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of two unlicensed personnel (ULP-C, ULP-D) with records reviewed. Refer to licensing order at Statute 144G.64, (a) (3). The licensee failed to ensure direct care staff completed the required amount of dementia care training in the required time frame for two of four employees (unlicensed personnel (ULP)-C, licensed assisted living director (LALD)-A) with	0 250		

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0 250	Continued From page 9 records reviewed. Refer to licensing order at Statute 144G.64, (a)(5). The licensee failed to ensure staff completed the required training for all topics for dementia care for two of two employees (unlicensed personnel (ULP)-D, registered nurse (RN)-B), with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 2. The licensee failed to ensure an assessment for self-administration of medication for one of one resident (R1) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 10. (a)(2). The licensee failed to ensure the Registered Nurse (RN) developed written procedures for unplanned time away from home. In addition, the licensee failed to ensure two of two unlicensed personnel (ULP-C, ULP-D) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. Refer to licensing order at Statute 144G.71, Subd. 19. The licensee failed to ensure access to keys for medications was secure. Refer to licensing order at Statute 144G.72, Subd. 3. The licensee failed to include in the service plan a written statement of the treatment or therapy services that would be provided and develop and maintain a current individualized treatment and therapy management record for one of one resident (R1) with record reviewed. Refer to licensing order at Statute 144G.72, Subd. 4. The licensee failed to ensure the registered nurse (RN) specified, in writing,	0 250		

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0 250	Continued From page 10 specific instructions and documented those instructions in the resident record for one of one resident (R1) and unlicensed personnel (ULP-C, ULP-D) were instructed in the proper methods and had demonstrated the ability to competently follow the procedures, with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 5. The licensee failed to ensure documentation and administration of treatment as prescribed for one of one resident (R1) with record reviewed. Refer to licensing order at Statute 144G.72, Subd. 6. The licensee failed to ensure there were current treatment and therapy orders that included the frequency, duration, and other required information needed for one of one resident (R1) with record reviewed. Refer to licensing order at Statute 144G.83, Subd. 3. The licensee failed to ensure designate a qualified person to oversee staff training in the care of individuals with dementia. This had the potential to affect all residents, staff and visitors. Refer to licensing order at Statute 144G.90, Subd. 1. The licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for one of one resident (R1) with record reviewed. Forty-five (45) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided.	0 250		

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0 250	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with 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 observation, interview, and record review, the licensee failed to provide a copy of the uniform disclosure of assisted living services and amenities (UDALSA) prior to providing assisted living (AL) services, for one of one resident (R1) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than	0 430		

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0 430	Continued From page 12	0 430		

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 began receiving assisted living services on August 1, 2021.

R1's Service Plan dated August 1, 2021, unsigned, indicated "Services Provided" were bathing assistance, bathing reminder, behavior management (anxiety, repetitive, self injury, self isolation, sexual inappropriateness, verbal aggression), manage symptoms (depression, wandering, other mental health need), dressing a.m., drinking assistance, housekeeping, laundry, linen change, meal assistance, meal reminder, medication administration, nail care, record blood glucose, record blood pressure, record pulse, remove garbage, skin care, socialization, therapeutic exercises, shopping assistance as needed and symptom screen.

On February 1, 2022, at 7:31 a.m. unlicensed personnel (ULP)-C was observed to check R1's blood pressure, pulse, blood sugar and administer medications to R1.

R1's record lacked evidence the resident had received a copy of the UDALSA prior to receiving services on August 1, 2021.

On January 31, 2022, at 9:56 a.m. licensed assisted living director (LALD)-A stated he was unaware of what the UDALSA was. LALD-A confirmed the current residents had not received

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0 430	Continued From page 13 the UDALSA. The licensee policy Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated August 1, 2021, indicated "[Name of AL] will provide a "Uniform Disclosure of Assisted Living Services and Amenities" (UDALSA) to prospective residents prior to signing an Assisted Living contract". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced	0 460		

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0 460	Continued From page 14 by: Based on interview and record review, the licensee failed to provide a means for any residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all two (2) residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license and was licensed for a bed capacity of four residents. During the entrance conference on January 31, 2022, at approximately 9:56 a.m. licensed assisted living director (LALD)-A stated, "No" the facility did not have a system in place for residents to summon staff 24 hours per day. LALD-A stated, "Staff are here 24 hours per day and can't leave one minute" and staff "check on them often". Residents would have to "call out" for help. Registered nurse (RN)-B stated the residents had no call light or call pendent to utilize. The licensee's policy, 24 Hour Emergency Response dated August 1, 2021, indicated "Residents living at Robland home health care have access to 24-hour emergency response by	0 460		

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0 460	Continued From page 15 staff. 1. All residents are given instructions on the use of emergency response system upon move in and ongoing, as need. 2. Pressing the button on the emergency response button or pulling an emergency response cord will activate the response system which will notify a designated staff person". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable 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;	0 470		

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0 470	Continued From page 16 (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 observation, interview and record review, the licensee failed to ensure the staffing plan was developed to determine staffing levels to meet the needs of all residents, and the 24-hour staffing schedule was posted as required. 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 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: STAFFING PLAN The licensee failed to develop and implement a staffing plan for determining it's staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet 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 - ensured that the facility can respond promptly and effectively to individual resident emergencies	0 470		

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0 470	Continued From page 17 and to emergency, life safety, and disaster situations affecting staff or residents in the facility STAFFING SCHEDULE The licensee lacked a posted daily staffing schedule developed by the clinical nurse supervisor to include: -direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; -direct-care staff member's resident assignments or work location; and -be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building On January 31, 2022, at approximately 9:33 a.m. no posted staff schedule was observed in any area of the facility. On January 31, 2022, at approximately 9:56 a.m. licensed assisted living director (LALD)-A stated "what do you mean by staffing plan". LALD-A and registered nurse (RN)-B confirmed a daily staffing schedule was not posted. The licensee policy Staffing & Scheduling dated August 1, 2021, indicated "The clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. The clinical nurse supervisor will develop a 24-hour daily staffing schedule that will identify: direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked, and the direct-care staff member's resident assignments or work location. The daily work schedule must	0 470		

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0 470	Continued From page 18 be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 485 SS=F	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 485		

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review, the licensee failed to ensure a menu prepared in advance included all meals and snacks. 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, 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:

The licensee lacked a menu prepared at least one week in advance which was made available to all residents, including encouragement of residents' involvement in the menu planning. In addition, the licensee lacked to serve meals according to the recommended dietary allowance in the United States Department of Agriculture guidelines.

On January 31, 2022, at 9:56 a.m. during the entrance conference, registered nurse (RN)-B stated, "we don't have a menu written down yet". RN-B stated food was "prepared fresh" and licensed assisted living director (LALD)-A "buys the groceries". RN-B stated between herself and LALD-A "we decide" what the residents "will eat".

On January 31, 2022, at 11:32 a.m. RN-B verified residents were not involved in menu planning.

On January 31, 2022, at 12:13 p.m. unlicensed personnel (ULP)-C was observed to prepare and serve R1 pasta with chicken and cream sauce

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0 485	Continued From page 20 and ketchup squirted on top, extra chicken on the side, potatoes and a glass of water for lunch. No other food or fluids were offered to R1. On February 1, 2022, at approximately 7:31 a.m. ULP-C was observed to serve R1 pancakes, scrambled eggs, a scoop of strawberry jam, coffee and water for the breakfast meal. No other food or fluids were offered to R1. On February 1, 2022, at approximately 11:16 a.m. ULP-C was observed to prepare lentil vegetable soup, chicken and pasta with red colored sauce and cooked scrambled eggs for the lunch meal. The licensee's policy, Food Service and Menu Planning dated August 1, 2021, indicated the licensee would "offer to provide or make available at least three meals daily with snacks available seven days per week according to the recommended dietary allowances in the USDA guidelines, including seasonal fresh fruit and fresh vegetables." Menus would be prepared at least one week in advance and made available to all residents and the licensee would encourage residents' involvement in menu planning. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for	0 490		

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	34623	A. BUILDING: _____ B. WING _____	02/02/2022

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0 490	Continued From page 21 transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a daily program of social and recreational activities. This had the potential to affect all residents receiving assisted living 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), 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:	0 490		

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0 490	Continued From page 22 R1's diagnoses included, but were not limited to, dementia and diabetes. R1's Master Care Plan dated December 20, 2021, indicated "activity capabilities needs cueing to participate in activities. Note: need to encourage to socialize and get involved activities". Spiritual/cultural traditions were religion "Muslim" and significant spiritual traditions was "prayer" five times a day. There was no other documented information for activities on R1's care plan. On January 31, 2022, and February 1, 2022, during survey hours at the establishment, R1 was observed to come out of his room for meals and independently walked for exercise. On January 31, 2022, at approximately 9:56 a.m. licensed assisted living director (LALD)-A and registered nurse (RN)-B stated activities were provided, but there was no calendar schedule for activities. LALD-A stated activities were not being offered outside of the establishment right now. LALD-A and RN-B stated R1 listened to the radio, walked, but had vision problems and did not like to do anything. RN-B stated activities were noted in the residents' care plans. On February 2, 2022, at 9:38 a.m. RN-B confirmed the licensee was not providing culturally sensitive programs and was not providing a daily program of social and recreational activities. The licensee's policy, Activity Programming dated August 1, 2021, indicated the licensee would provide a wide range of activities and social recreation for its residents. "A monthly activity	0 490		

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0 490	Continued From page 23 calendar will be created and available to all residents" and the activities may include: "social events, religious events, exercise and wellness events, creative opportunities, intellectual opportunities, cultural events, and volunteer opportunities. Robland home health care encourages outings and engagements outside the facility and in the community". No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This had the potential to affect all residents, staff and visitors.	0 510		

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0 510	Continued From page 24 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: BLOOD SUGAR CHECK On February 1, 2022, at 7:31 a.m. unlicensed personnel (ULP)-C was observed to put on gloves and check R1's blood sugar. Without removing the gloves, ULP-C picked up a pulse oximeter (equipment used to check oxygen saturation). ULP-C failed to wash hands before and after checking R1's blood sugar. Registered nurse (RN)-B was present and prompted ULP-C to wash hands after checking R1's blood sugar. RN-B verified at that time. The licensee's policy, Blood Sugar Testing - Single Equipment Use dated August 1, 2021, indicated "explain the procedure to the resident. Wash your hands and have resident wash hands if possible. Put on gloves. Store the glucometer in a clean and dry location. Un-glove, discard gloves, and wash hands." COVID-19 The licensee failed to post signage of restrictions for COVID-19 at facility entrances, screen residents for COVID-19, and ensure employees wore eye protection and a facial mask. On January 31, 2022, at 9:33 a.m. upon entrance to the facility, no signage was observed posted at	0 510		

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0 510	Continued From page 25	0 510		

the facility entrances for screening or restrictions for infection prevention and control for COVID-19. Unlicensed personnel (ULP)-C was not wearing eye protection, and was wearing a cloth facial mask. RN-B was also observed not wearing eye protection. At 9:49 a.m., licensed assisted living director (LALD)-A was observed not wearing eye protection. At 11:02 a.m., RN-B verified there was no signage posted at the facility entrance.

R1's record lacked evidence of documented daily screening of temperature and COVID-19 symptoms.

On February 2, 2022, at 12:52 p.m. RN-B stated, "No" to residents being screened daily for temperature and COVID-19 symptoms.

The Centers for Disease Control and Prevention (CDC) webpage titled "Symptoms of COVID-19" updated February 22, 2021, indicated "People with COVID-19 have had a wide range of symptoms reported ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Anyone can have mild to severe symptoms. People with these symptoms may have COVID-19: Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, Diarrhea, This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19. Older adults and people who have severe underlying medical conditions like heart or lung disease or diabetes seem to be at higher risk for developing more serious complications from COVID-19 illness".

The MDH COVID-19 Guidance: Long-term Care

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0 510	Continued From page 26 Indoor Visitation for Nursing Facilities and Assisted Living-type Settings guidance dated May 20, 2021, indicated facilities should actively screen all residents for fever and respiratory symptoms of illness at least daily and increase monitoring of ill residents to at least three times daily. The CDC guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated Sept. 10, 2021, indicated ensure everyone is aware of recommended IPC practices in the facility. Post visual alert icons (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) with instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations. Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so that they can be properly managed: 1) a positive viral test for SARS-CoV-2, 2) symptoms of COVID-19, or 3) who meets criteria for quarantine or exclusion from work. Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility. Implement Universal Use of Personal Protective Equipment for HCP If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below: Facilities could consider use of	0 510		

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0 510	Continued From page 27 NIOSH-approved N95 or equivalent or higher-level respirators for HCP working in other situations where multiple risk factors for transmission are present. One example might be if the patient is unvaccinated, unable to use source control, and the area is poorly ventilated. Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. The Minnesota Department of Health (MDH) guidance titled, COVID-19 Guidance: Long-term Care Indoor Visitation for Nursing Facilities and Assisted Living Settings, updated December 29, 2021, indicated this guidance replaces previous Minnesota Department of Health (MDH) visitation guidance for Minnesota's long-term care settings, such as nursing facilities, skilled nursing facilities, and assisted living facilities. The following core principles of COVID-19 infection prevention are consistent with Centers for Disease Control and Prevention (CDC) guidance and should be adhered to at all times. Refer to #1 on the CMS FAQ. Per CMS QSO 20-39, core principles include: Having staff wear face masks and other needed personal protective equipment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who	0 550		

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0 550	Continued From page 28	0 550		

are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to post information related to the grievance procedure, resident advocacy information, and information for reporting suspected maltreatment. 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 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 postings in a conspicuous location and a disclosure of resident advocacy to include:
-a posting with all required content of the licensee's grievance procedure and the name and email contact information for the individuals who are responsible for handling grievances;
-contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and

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0 550	Continued From page 29 Developmental Disabilities; and -number and contact information and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On January 31, 2022, at approximately 9:33 a.m. no posted facility grievance procedure was observed in any area of the facility. On February 1, 2022, at 12:35 p.m. during observation of information posted in the establishment with licensed assisted living director (LALD)-A, LALD-A confirmed there was no posted facility grievance procedure. The licensee's policy, Complaint/Grievance Posting dated August 1, 2021, indicated the licensee would "post, in a conspicuous place, information about our complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. The posting will also have the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities. In addition, the posting will include information for reporting suspected maltreatment to the Minnesota Adult Abuse Center." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 30 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan included statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults for identified vulnerabilities for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included, but were not limited to, dementia and diabetes. On February 1, 2022, at 7:31 a.m. unlicensed	0 630		

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0 630	Continued From page 31 personnel (ULP)-C was observed to check R1's blood pressure, pulse, blood sugar and administer medications to R1. R1 was wearing eye glasses. R1's Individual Abuse Prevention Plan dated December 20, 2021, indicated vulnerabilities included, but were not limited to, medication management, physical for musculoskeletal/neurological/speech/vision, alcohol and/or history of use, difficulty using phone, difficulty communicating-may not report abuse, dementia, disorientated to person/place/time/disorientation varies by the time of day/disorientation throughout the day and night, resident is at risk of falling and behaviors of agitation/hoarding/self injury/sexually inappropriate/socially inappropriate/verbal aggression/depression/delusions/post traumatic stress disorder. The plan included comments about the vulnerabilities, but lacked evidence of specific measures for "plan of action" to minimize the risk of abuse for the identified vulnerabilities and for medication management lacked to indicate staff administered medications to R1. On February 2, 2022, at 8:57 a.m. registered nurse (RN)-B verified R1's Individual Abuse Prevention Plan lacked evidence of specific measures for "plan of action" to minimize the risk of abuse for the identified vulnerabilities above. The licensee's policy, 44 Vulnerable Adult Maltreatment Prevention and Reporting dated August 1, 2021, indicated consistent with Assisted Living licensure regulations, the licensee would develop individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information.	0 630		

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0 630	Continued From page 32 TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced	0 650		

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0 650	Continued From page 33 by: Based on observation, interview and record review, the licensee failed to ensure employee records included all required content for one of two unlicensed personnel (ULP-C) 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: The licensee lacked evidence of verification that required health screenings had taken place and the date of those screenings for ULP-C who was providing assisted living services. ULP-C's date of hire was December 27, 2021, and was observed to provide direct care services to R1 during the survey. ULP-C's record identified chest x-ray results dated December 21, 2021. The report indicated a chest x-ray was completed due to a positive Quantiferon (blood test that aids in the detection of Mycobacterium tuberculosis, an interferon-gamma release assay commonly know as an IGRA); however, ULP-C's record lacked documented evidence of the Quantiferon blood test, including the date of the test and qualitative results.	0 650		

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0 650	Continued From page 34 On January 31, 2021, at 1:51 p.m. registered nurse (RN)-B confirmed ULP-C's record lacked documented evidence for the Quantiferon blood test. The licensee's policy, Tuberculosis Screening dated August 1, 2021, indicated the licensee would "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 (MMWR). Screening would be conducted as follows: New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. Staff TB screening results will be kept in each employee medical file." The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated "All reports or copies of TST or IGRA results and any related chest X-ray and medical evaluations should be maintained in the employee ' s record. IGRA documentation should include the date of the test (i.e., month, day, year), the qualitative results (i.e., positive, negative, indeterminate or borderline) and the quantitative assay (i.e., Nil, TB and Mitogen concentrations or spot counts)". No further information was provided.	0 650		

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0 650	Continued From page 35 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines. 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	0 660		

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0 660	Continued From page 36	0 660		

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:

The licensee lacked screening of employees for TB symptoms upon hire and failed to train employees on the licensee's TB infection control plan.

Unlicensed personnel (ULP)-C's date of hire was December 27, 2021, and was observed to provide direct care services to R1 during the survey.

ULP-D's date of hire was August 5, 2021, and provided direct care services to the licensee's residents.

ULP-C and ULP-D's employee records lacked evidence of screening for TB symptoms upon hire and training for the licensee infection control plan for TB on how to implement early recognition, isolation, and referral procedure, especially any sections that employees are responsible for implementing.

On January 31, 2022, at approximately 12:48 p.m. registered nurse (RN)-B stated all of the licensee's employees would lack screening for TB symptoms.

On February 1, 2022, at approximately 11:09 a.m. RN-B further stated she had not provided training on the licensee's TB infection control plan to any employees.

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0 660	Continued From page 37 The licensee's policy, Tuberculosis Screening dated August 1, 2021, indicated the licensee would establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States CDC, Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). Staff would be educated regarding TB at time of hire. Content of the training would include the licensee's infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing. New staff would be screened for active signs of TB using the Baseline TB Screening Tool for HCWs and the screening results would be kept in each employee medical file. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated "an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and TB training is required at time of hire for all health care workers (HCWs). Content should focus on basic information about: TB pathogenesis and transmission, Signs and symptoms of active TB disease, and Your health care setting ' s infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing". No further information was provided.	0 660		

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0 660	Continued From page 38 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure emergency exit diagrams were posted, failed to develop an all-hazards emergency preparedness (EP)	0 680		

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0 680	Continued From page 39	0 680		

program and plan to include Appendix Z required elements. This had the potential to affect all two (2) residents in the facility, staff and any visitors.

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

The findings include:

EMERGENCY EXIT DIAGRAM
The licensee lacked posted emergency exit diagrams in the facility and had not provided emergency exit diagrams to the residents.

On January 31, 2022, at approximately 9:33 a.m. observation revealed there was no posted emergency disaster plan inside the facility.

On February 1, 2022, at 12:35 p.m. observation with licensed assisted living director (LALD)-A revealed there were no posted emergency exit diagrams posted on the upper or lower levels of the facility. At that time, LALD-A stated he had not provided emergency exit diagrams to the residents.

EMERGENCY PREPAREDNESS PLAN
The licensee lacked a posted emergency disaster plan prominently and the licensee's Emergency Preparedness Plan dated August 1, 2021 lacked required information according to Emergency Preparedness: Appendix Z.

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0 680	Continued From page 40 On January 31, 2022, at approximately 9:56 a.m. LALD-A stated he was not familiar with Appendix Z. On February 2, 2022, at 12:13 p.m. LALD-A was interviewed regarding the licensee's Emergency Preparedness Plan. LALD-A confirmed the licensee's Emergency Preparedness Plan lacked the following: - addressing how the licensee would coordinate with other health care facilities. as well as community on a whole during emergency or disaster; - risk assessment which considered hazards like care related emergencies, cyber-attacks, normal supply of essential resources and medical supplies, should consider duration of interruptions, consider emerging infectious diseases (EIDs), arrangements/contracts to re-establish utility services; -an all hazards approach, including EIDs as applicable, develop strategies for addressing facility and community based risks (evacuation plans, back-up plans) - identification of at risk population needs like maintaining independence, communication, transportation, supervision, medical care and qualified person authorized in writing to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure addressing alternate sources of energy to maintain food, water medical supplies, pharmaceutical supplies, alternate sources of energy to maintain: temperatures to protect resident health/safety, safe and sanitary storage of provisions and sewage and waste disposal; - policy and procedure for a system to track the	0 680		

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0 680	Continued From page 41 location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure addressing system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure addressing use of volunteers, including the process/role for integration; - policy and procedures addressing development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; -communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers - communication plan which includes primary and alternate means of communication with facility staff and Federal, State, tribal, regional and local emergency management agencies; - communication plan which includes method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4); - communication plan which includes means to providing information about the facility occupancy,	0 680		

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0 680	Continued From page 42 needs, and its ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; and - communication plan which includes method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives The licensee's policy, Emergency Preparedness Plan Appendix Z Compliance dated August 1, 2021, indicated "It is the intent that Robland Home Health Care has in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance" and the licensee's "emergency preparedness plan will include all required elements of appendix Z." The licensee's policy, Disaster Planning and Emergency Preparedness dated August 1, 2021, indicated "Robland Home Health Care will have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS Appendix Z. 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 emergency. All of these elements are incorporated into the Appendix Z requirements. Robland Home Health Care will provide a building emergency exit diagram to all residents. Robland Home Health Care will post emergency exit diagrams on each floor of the facility." No additional information was provided.	0 680		

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0 680	Continued From page 43 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 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 provide smoke alarms in rooms used for sleeping and ensure smoke alarms are interconnected so that the actuation of one alarm causes all alarms in the dwelling to actuate as	0 780		

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0 780	Continued From page 44 required. This had the potential to directly 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 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 residents). The findings include: On January 31, 2022, between 10:45 a.m. and 11:15 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed basement bedroom #2 did not have a smoke alarm installed. LALD-A verbally confirmed survey staff observations during the facility tour. LALD-A stated he would get it installed. No further information was provided. 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	0 790		

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0 790	Continued From page 45 minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure installation and maintenance of portable fire extinguishers at the facility. This had the potential to directly 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) 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 residents). The findings include: On January 31, 2022, from approximately 10:45 a.m. to 11:15 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed there were no portable fire extinguishers in the facility. LALD-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 790		

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0 790	Continued From page 46 (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 interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly 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) 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 residents). The findings include: On January 31, 2022, from approximately 10:45 a.m to 11:15 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the basement exit door had been sealed shut with duct tape on the exterior and	0 800		

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0 800	Continued From page 47 interior of the frame. Foam had also been attached to the face of the door obstructing visibility through the window. Exit doors must be operational and well maintained. LALD-A removed foam and duct tape from the interior and exterior of the exit door and frame at the time of the survey. LALD-A verbally confirmed survey staff observations during the facility tour. LALD-A stated the door had been sealed and covered in foam to reduce the amount of cold air penetration during the winter months. 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 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	0 810		

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0 810	Continued From page 48 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 observation, interview, and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly 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 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 residents). The findings include: On January 31, 2022, from approximately 10:45 a.m. to 11:15 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff	0 810		

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	34623	A. BUILDING: _____ B. WING _____	02/02/2022

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0 810	Continued From page 49 observed the exit plan for the basement did not include the number and location of bedrooms. LALD-A verbally confirmed survey staff observations during the facility tour. During the interview on January 31, 2022, at 11:30 a.m., LALD-A stated he would get the plans updated, start the training of his staff and residents, and start the evacuation drills. Survey staff would have expected to see at least one staff training documented and three evacuation drills completed at the time of the survey. A review of the Fire Safety Plan showed the following: 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar, and no written instructions for addressing any unique situation during evacuation especially for residents who are wheelchair-bound and need assistance during an evacuation. 2. No record of required employee evacuation drills. 3. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. 4. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation.	0 810		

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0 810	Continued From page 50 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any	0 900		

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0 900	Continued From page 51 additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the licensee contract contained terms as required and had provided the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract. This had the potential to affect all current 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: The licensee contract lacked terms concerning the provision of housing, assisted living services, resident's service plan and failed to provide a complete, unsigned copy of its contract to the Office of Ombudsman for Long-Term Care as required. R1's Assisted Living Contract for Housing and Services dated August 1, 2021, indicated the following: -"Resident agrees to pay $_____per month. Rent is to be paid on the 1st of each month. Rent paid after the 5th of the month is subject to a late fee of 3% [percent]. Resident is responsible for their	0 900		

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0 900	Continued From page 52	0 900		

rent, as we currently do not accept housing support payments".

The contract lacked any other documented information for provision of housing.

-the licensee "provides the following services at this facility: Medication management, Activities of Daily Living, Treatments and Therapies, Mobility Services, Safety Checks" and indicated "For a full list of services an assisted living facility may perform, see attached document of services;" however, there was no attached document of services as indicated.

In addition, the contract lacked documented evidence of terms concerning the provision of the resident's service plan.

On February 1, 2022, at 7:31 a.m. unlicensed personnel (ULP)-C was observed to provide direct care services to R1.

On February 2, 2022, at approximately 12:13 p.m. licensed assisted living director (LALD)-A verified R1's contract lacked the content listed above, and confirmed an unsigned copy of the licensee's contract had not been sent to the Ombudsman as required.

The licensee's policy, Signing an Assisted Living Contract dated August 1, 2021, indicated when a prospective resident decides to move into the licensee home an Assisted Living contract would be signed and received by the facility and the licensee would fill in all the blanks of the contract and provide the prospective resident and/or responsible person a copy of the appropriate assisted living contract and the license would give one copy to the prospective resident and/or

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0 900	Continued From page 53 responsible person and retain one copy for the resident record. The policy did not address the content required for an assisted living contract or the requirement to provide a copy of the contract to the Office of Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive	0 910		

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0 910	Continued From page 54 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's Service Plan dated August 1, 2021, unsigned, indicated "Services Provided" were bathing assistance, bathing reminder, behavior management (anxiety, repetitive, self injury, self isolation, sexual inappropriateness, verbal aggression), manage symptoms (depression, wandering, other mental health need), dressing a.m., drinking assistance, housekeeping, laundry, linen change, meal assistance, meal reminder, medication administration, nail care, record blood glucose, record blood pressure, record pulse, remove garbage, skin care, socialization, therapeutic exercises, shopping assistance as needed and symptom screen. On February 1, 2022, at 7:31 a.m. unlicensed personnel (ULP)-C was observed to provide direct care services to R1. R1's Assisted Living Contract for Housing and Services dated August 1, 2021, lacked the following required content: -the authorized agent for the facility On February 2, 2022, at approximately 12:13 p.m. licensed assisted living director (LALD)-A confirmed R1's contract lacked the above content. LALD-A verified the licensee contract would lack the same for all residents. The licensee's policy, Signing an Assisted Living Contract dated August 1, 2021, indicated when a prospective resident decides to move into the licensee home an Assisted Living contract would	0 910		

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0 910	Continued From page 55 be signed and received by the facility and the licensee would fill in all the blanks of the contract and provide the prospective resident and/or responsible person a copy of the appropriate assisted living contract and the license would give one copy to the prospective resident and/or responsible person and retain one copy for the resident record. The policy did not address the content required for an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 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	0 920		

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0 920	Continued From page 56 requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Service Plan dated August 1, 2021, unsigned, indicated "Services Provided" were bathing assistance, bathing reminder, behavior management (anxiety, repetitive, self injury, self isolation, sexual inappropriateness, verbal aggression), manage symptoms (depression, wandering, other mental health need), dressing a.m., drinking assistance, housekeeping, laundry, linen change, meal assistance, meal reminder, medication administration, nail care, record blood glucose, record blood pressure, record pulse, remove garbage, skin care, socialization, therapeutic exercises, shopping assistance as needed and symptom screen. On February 1, 2022, at 7:31 a.m. unlicensed personnel (ULP)-C was observed to provide direct care services to R1.	0 920		

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0 920	Continued From page 57 R1's Assisted Living Contract for Housing and Services dated August 1, 2021, lacked the following required content: -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; and -a delineation of the cost and nature of any other services to be provided for an additional fee On February 2, 2022, at approximately 12:13 p.m. licensed assisted living director (LALD)-A confirmed R1's contract lacked the above content. LALD-A verified the licensee contract would lack the same for all residents. The licensee's policy, Signing an Assisted Living Contract dated August 1, 2021, indicated when a prospective resident decides to move into the licensee home an Assisted Living contract would be signed and received by the facility and the licensee would fill in all the blanks of the contract and provide the prospective resident and/or responsible person a copy of the appropriate assisted living contract and the license would give one copy to the prospective resident and/or responsible person and retain one copy for the resident record. The policy did not address the content required for an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 Contract information	0 930		

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0 930	Continued From page 58 (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 930		

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0 930	Continued From page 59 R1's Service Plan dated August 1, 2021, unsigned, indicated "Services Provided" were bathing assistance, bathing reminder, behavior management (anxiety, repetitive, self injury, self isolation, sexual inappropriateness, verbal aggression), manage symptoms (depression, wandering, other mental health need), dressing a.m., drinking assistance, housekeeping, laundry, linen change, meal assistance, meal reminder, medication administration, nail care, record blood glucose, record blood pressure, record pulse, remove garbage, skin care, socialization, therapeutic exercises, shopping assistance as needed and symptom screen. On February 1, 2022, at 7:31 a.m. unlicensed personnel (ULP)-C was observed to provide direct care services to R1. R1's Assisted Living Contract for Housing and Services dated August 1, 2021, lacked the following required content: -contact information for the Ombudsman for Mental Health and Developmental Disabilities On February 2, 2022, at approximately 12:13 p.m. licensed assisted living director (LALD)-A confirmed R1's contract lacked the above content. LALD-A verified the licensee contract would lack the same for all residents. The licensee's policy, Signing an Assisted Living Contract dated August 1, 2021, indicated when a prospective resident decides to move into the licensee home an Assisted Living contract would be signed and received by the facility and the licensee would fill in all the blanks of the contract and provide the prospective resident and/or responsible person a copy of the appropriate	0 930		

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0 930	Continued From page 60 assisted living contract and the license would give one copy to the prospective resident and/or responsible person and retain one copy for the resident record. The policy did not address the content required for an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support	0 940		

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0 940	Continued From page 61 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 observation, interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Service Plan dated August 1, 2021, unsigned, indicated "Services Provided" were bathing assistance, bathing reminder, behavior management (anxiety, repetitive, self injury, self isolation, sexual inappropriateness, verbal aggression), manage symptoms (depression, wandering, other mental health need), dressing a.m., drinking assistance, housekeeping, laundry, linen change, meal assistance, meal reminder, medication administration, nail care, record blood glucose, record blood pressure, record pulse,	0 940		

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0 940	Continued From page 62 remove garbage, skin care, socialization, therapeutic exercises, shopping assistance as needed and symptom screen. On February 1, 2022, at 7:31 a.m. unlicensed personnel (ULP)-C was observed to check R1's blood pressure, pulse, blood sugar and administer medications to R1. R1's Assisted Living Contract for Housing and Services dated August 1, 2021, indicated "All fees associated with resident care shall be paid by MA [medical assistance] Waiver/ Resident; Or if neither party is responsible , please denote the responsible payee here:_____". The contract lacked the following required content: -whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; -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 February 2, 2022, at approximately 12:13 p.m. licensed assisted living director (LALD)-A confirmed R1's contract lacked the above content. LALD-A verified the licensee contract would lack the same for all residents. The licensee policy Signing an Assisted Living Contract dated August 1, 2021, indicated when a prospective resident decides to move into the	0 940		

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0 940	Continued From page 63 licensee home an Assisted Living contract would be signed and received by the facility and the licensee would fill in all the blanks of the contract and provide the prospective resident and/or responsible person a copy of the appropriate assisted living contract and the license would give one copy to the prospective resident and/or responsible person and retain one copy for the resident record. The policy did not address the content required for an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
0 980 SS=F	144G.51 ARBITRATION (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. (b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 980		

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0 980	Continued From page 64 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's Service Plan dated August 1, 2021, unsigned, indicated "Services Provided" were bathing assistance, bathing reminder, behavior management (anxiety, repetitive, self injury, self isolation, sexual inappropriateness, verbal aggression), manage symptoms (depression, wandering, other mental health need), dressing a.m., drinking assistance, housekeeping, laundry, linen change, meal assistance, meal reminder, medication administration, nail care, record blood glucose, record blood pressure, record pulse, remove garbage, skin care, socialization, therapeutic exercises, shopping assistance as needed and symptom screen. On February 1, 2022, at 7:31 a.m. unlicensed personnel (ULP)-C was observed to provide direct care services to R1. R1's Assisted Living Contract for Housing and Services dated August 1, 2021, lacked the following required content: - an assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action; and - an arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to	0 980		

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0 980	Continued From page 65 Minnesota law and any other applicable federal or local law. On February 2, 2022, at approximately 12:13 p.m. licensed assisted living director (LALD)-A confirmed R1's contract failed to address the above content. LALD-A verified the licensee contract would lack the same for all residents. The licensee's policy, Signing an Assisted Living Contract dated August 1, 2021, indicated when a prospective resident decides to move into the licensee home an Assisted Living contract would be signed and received by the facility and the licensee would fill in all the blanks of the contract and provide the prospective resident and/or responsible person a copy of the appropriate assisted living contract and the license would give one copy to the prospective resident and/or responsible person and retain one copy for the resident record. The policy did not address the content required for an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 980		
01370 SS=F	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne	01370		

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01370	Continued From page 66 pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations contained all the required training for two of two unlicensed personnel (ULP-C, ULP-D) with records reviewed.	01370		

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01370	Continued From page 67 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: ULP-C had a hire date of December 27, 2021, and ULP-D had a hire date of August 5, 2021. On February 1, 2022, at 7:31 a.m. ULP-C was observed to check R1's blood pressure, pulse, blood sugar and administer medications to R1. ULP-C and ULP-D's records lacked evidence of training and competency evaluation for standby assistance techniques and how to perform them. On January 31, 2022, at approximately 12:48 p.m. registered nurse (RN)-B verified ULP-C and ULP-D lacked training and competency evaluation for standby assistance techniques and how to perform them. RN-B further verified all other employees would lack the same. The licensee's policy, Competency Training Evaluations dated August 1, 2021, indicated training and competency evaluations of ULP would be conducted by a RN, or another instructor may provide the training in conjunction with a RN and the training and competency evaluations for all ULP would include standby assistance techniques and how to perform them.	01370		

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01370	Continued From page 68 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the facility for	01440		

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01440	Continued From page 69 one of two unlicensed personnel (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D's employee record lacked documentation of a registered nurse (RN) supervising ULP-D performing delegated tasks. ULP-D was hired on August 5, 2021, to provide direct care services to residents at the assisted living. ULP-D's record indicated ULP-D was trained and competency evaluated for medication administration on August 20, 2021, and was observed by RN-B for personal cares on December 1, 2021, and medication administration on December 5, 2021. On January 31, 2022, at 3:25 p.m. RN-B reviewed ULP-D's record and confirmed ULP-D lacked documented direct supervision of performing delegated tasks within 30 calendar days as required. The licensee's policy, Supervision of Staff Delegated Services dated August 1, 2021, indicated direct supervision of staff performing delegated tasks "must" be provided within 30	01440		

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01440	Continued From page 70 calendar days after the date on which the individual begins working for the licensee and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and	01470		

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01470	Continued From page 71 Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for two of two unlicensed personnel (ULP-C, ULP-D) with records reviewed. This practice resulted in a level two violation (a	01470		

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01470	Continued From page 72 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: ULP-C had a hire date of December 27, 2021, and ULP-D had a hire date of August 5, 2021. On February 1, 2022, at 7:31 a.m. ULP-C was observed to check R1's blood pressure, pulse, blood sugar and administer medications to R1. ULP-C and ULP-D's records lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - an overview of this chapter (assisted living statutes); - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; On January 31, 2022, at approximately 3:40 p.m.	01470		

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01470	Continued From page 73 licensed assisted living director (LALD)-A verified ULP-C, ULP-D, and all other employees' records lacked the above training for orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, as required. The licensee's policy, Orientation of Staff and Supervisors & Content dated August 1, 2021, indicated orientation "must be" completed once for each staff person and is not transferable to another home care provider, "must complete" the orientation to assisted living facility requirements before providing assisted living services to residents and the orientation "must contain" the above topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete.	01540		

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01540	Continued From page 74 Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct care staff completed the required amount of dementia care training in the required time frame for two of four employees (unlicensed personnel (ULP)-C, licensed assisted living director (LALD)-A) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C's date of hire was December 27, 2021, and was observed to provide direct care to residents under the licensee's Assisted Living with Dementia Care license. ULP-C's employee record included Tally of Education by Individual Employee which included, but was not limited to, "Dementia and Alzheimer's Training;" however, there was no documented evidence training was completed. In addition, ULP-C's record included Assisted Living Minnesota Orientation Checklist and Requirements sheets for Educare training topics,	01540		

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which had a created date by Educare of July 31, 2019. The sheets identified the "subject matter" for dementia training was "dementia training for memory care providers" for housing with services (HWS) establishments and arranged home care providers in HWS settings and the topics were: explanation of Alzheimer's disease and other dementia's, assistance with activities of daily living, problem solving with challenging behaviors and communication skills, and RN-B's signature for completion on December 27, 2021.

ULP-C's record lacked evidence of required training for the area of person-centered planning and service delivery, and evidence a total of eight (8) hours of training was completed within 80 hours of employment start date.

On January 31, 2022, at approximately 12:48 p.m. RN-B verified the training content of ULP-C's employee record.

On February 1, 2022, at 10:24 a.m. LALD-A stated ULP-C had not "seen any videos" for dementia training and "probably did not have" the required "eight hours" of training for dementia. LALD-A stated the videos staff watched for dementia training were on a flash drive.

LALD-A
LALD-A's date of hire was January 1, 2020, and provided direct cares to residents under the licensee's Assisted Living with Dementia Care license.

LALD-A's employee record included, but was not limited to, Tally of Education by Individual Employee for calendar year 2020, which included, but was not limited to, "Dementia and Alzheimer's Training" date of March 1, 2020, a total of six

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01540	Continued From page 76	01540		

hours (videos per interview above), but it did not indicate what topics were viewed by video for dementia training.

In addition, LALD-A's record identified the following sheets for "Knowledge Assessment Dementia" for "Introduction and Overview, Communication, Activities of daily Living, Behaviors vs [versus] Symptoms. The Journey" were in LALD-A's employee record, but were not completed for training.

LALD's record lacked evidence of a total of eight (8) hours within 80 hours of employment start date and required training for the areas of an explanation of Alzheimer's disease and other dementia's; assistance with activities of daily living; problem solving with challenging behaviors; communication skills; and person-centered planning and service delivery.

On January 31, 2022, at 12:48 p.m. RN-B verified LALD-A's employee record lacked the above.

On January 31, 2022, at 11:50 a.m. LALD-A stated the licensee did not do online training for Educare, but used Educare training materials which were completed in person with staff.

The licensee's policy, Dementia Training dated August 1, 2021, indicated "Assisted Living with Dementia Care licensed facilities: Supervisors of direct care staff will complete eight (8) hours of initial training within 120 hours of the employment start date. Direct care employees will complete eight (8) hours of initial training within 80 hours of the employment start date. If an employee has written proof of completing the required training within the past 18 months this may satisfy the initial training requirements. Required dementia

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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
01540	Continued From page 77 training topics include: An explanation of Alzheimer's disease and other dementia's; Assistance with activities of daily living; Problem solving with challenging behaviors; Communication skills; Person centered planning and service delivery". The licensee's policy ALDC (assisted living dementia care) Additional Dementia Staff Training dated August 1, 2022, indicated staff who work with residents with Alzheimer's disease and other dementia's would have proper training for the tasks assigned. Training would be documented and will indicate staff knowledge and understanding of such training. Persons conducting such training will be qualified to train in the care of individuals with dementia. Staff would be trained to provide a person-centered care approach. All direct care staff assigned to provide care for residents with dementia would be trained to work with residents with Alzheimer's disease and other dementia's. Staff training would include the following topics: understanding cognitive impairment, and behavioral and psychological symptoms of dementia; and standards of dementia care, including nonpharmacological dementia care practices that are person-centered and evidence informed. No further information was provided. TIME PERIOD TO CORRECT: Fourteen (14) day	01540		
01560 SS=F	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the	01560		

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01560	Continued From page 78 past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff completed the required training for all topics for dementia care for two of two employees (unlicensed personnel (ULP)-D, registered nurse (RN)-B), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D's date of hire was August 5, 2021, and provided direct cares to residents under the Assisted Living with Dementia Care license.	01560		

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01560	Continued From page 79 ULP-D's employee record included Tally of Education by Individual Employee for calendar year 2021, which included, but was not limited to, "Dementia and Alzheimer's Training" date of August 9 through August 15, 2021, a total of six hours (videos per interview above); however, it did not indicate what topics were viewed by video for dementia training, and it lacked a signature by the trainer and the employee of it's completion. In addition, ULP-D's record included Assisted Living Minnesota Orientation Checklist and Requirements sheets for Educare training topics, which had a created date by Educare of July 31, 2019. The sheets identified the "subject matter" for dementia training was "dementia training for memory care providers" for housing with services (HWS) establishments and arranged home care providers in HWS settings, and the topics were: explanation of Alzheimer's disease and other dementia's, assistance with activities of daily living, problem solving with challenging behaviors and communication skills, and RN-B's signature for completion on August 5, 2021. ULP-D's record lacked evidence of required training for the area of person-centered planning and service delivery. On January 31, 2022, at approximately 12:48 p.m. RN-B verified the training content of ULP-D's employee record. RN-B RN-B's date of hire was February 7, 2020. RN-B's employee record included Assisted Living Minnesota Orientation Checklist and Requirements sheets for Educare training topics, which had a created date by Educare of July 31,	01560		

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01560	Continued From page 80 2019. The sheets identified the "subject matter" for dementia training was "dementia training for memory care providers" for housing with services (HWS) establishments and arranged home care providers in HWS settings and the topics were explanation of Alzheimer's disease and other dementia's, assistance with activities of daily living, problem solving with challenging behaviors and communication skills. RN-B signed the Assisted Living Minnesota Orientation Checklist and Requirements sheets, but there was no date for the signature of completion, and no hours for the time it took to complete the training. In addition, RN-B's employee record included Tally of Education by Individual Employee for calendar year 2020, which included, but not limited to, "Dementia and Alzheimer's Training" date of December 1, 2020, a total of six hours (videos per interview above); however, it did not indicate what topics were viewed by video for dementia training. RN-B's record lacked evidence of required training for the area of person-centered planning and service delivery. On January 31, 2022, at 11:42 a.m. RN-B stated she provided supervision of unlicensed staff, including training. RN-B stated she had training of dementia topics by videos and reading information through Educare (innovative training solutions), which all staff completed for dementia training. RN-B verified the training documented for videos did not indicate what topics were viewed by video for dementia training and a completion date was not documented for the Educare training. On January 31, 2022, at 11:50 a.m. licensed assisted living director (LALD)-A stated the	01560		

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01560	Continued From page 81	01560		

licensee did not do online training for Educare, but used Educare training materials which were completed in person with staff.

The licensee's policy, Dementia Training dated August 1, 2021, indicated "Assisted Living with Dementia Care licensed facilities: Supervisors of direct care staff will complete eight (8) hours of initial training within 120 hours of the employment start date. Direct care employees will complete eight (8) hours of initial training within 80 hours of the employment start date. If an employee has written proof of completing the required training within the past 18 months this may satisfy the initial training requirements. Required dementia training topics include: An explanation of Alzheimer's disease and other dementia's; Assistance with activities of daily living; Problem solving with challenging behaviors; Communication skills; Person centered planning and service delivery."

The licensee's policy ALDC (assisted living dementia care) Additional Dementia Staff Training dated August 1, 2022, indicated staff who work with residents with Alzheimer's disease and other dementia's would have proper training for the tasks assigned. Training would be documented and will indicate staff knowledge and understanding of such training. Persons conducting such training will be qualified to train in the care of individuals with dementia. Staff would be trained to provide a person-centered care approach. All direct care staff assigned to provide care for residents with dementia would be trained to work with residents with Alzheimer's disease and other dementia's. Staff training would include the following topics: understanding cognitive impairment, and behavioral and psychological symptoms of dementia; and

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01560	Continued From page 82 standards of dementia care, including nonpharmacological dementia care practices that are person-centered and evidence informed. No further information was provided. TIME PERIOD TO CORRECT: Fourteen (14) day	01560		
01640 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included a signature or other authentication	01640		

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01640	Continued From page 83	01640		

by the resident and the facility to document agreement on the services provided for one of one resident (R1) with record reviewed.

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

The findings include:

The licensee lacked signature and date for service plan no later than 14 calendar days after the date that services were first provided; and a revision of the service plan lacked a signature or other authentication by the licensee and by the resident documenting agreement on the services to be provided.

R1's start of care date was February 7, 2020.

On February 1, 2022, at 7:31 a.m. unlicensed personnel (ULP)-C was observed to check R1's blood pressure, pulse, blood sugar and administer medications to R1. At 7:52 a.m., RN-B was observed to set up medications into a weekly pill box for the dates of February 1 through February 8, 2022. During that time, R1 was observed to be walking up and down the hallway, and licensed assisted living director (LALD)-A stated R1 had amputation of foot and the shoes R1 was wearing helped R1 walk better.

R1's Daily Service Plan Home Care Clients was signed by RN-B, but it lacked a signature by the

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01640	Continued From page 84 client/responsible person and the date. R1's Service Plan dated August 1, 2021, unsigned, indicated "Services Provided" were bathing assistance, bathing reminder, behavior management (anxiety, repetitive, self injury, self isolation, sexual inappropriateness, verbal aggression), manage symptoms (depression, wandering, other mental health need), dressing a.m., drinking assistance, housekeeping, laundry, linen change, meal assistance, meal reminder, medication administration, nail care, record blood glucose, record blood pressure, record pulse, remove garbage, skin care, socialization, therapeutic exercises, shopping assistance as needed and symptom screen. R1's revised Service Plan dated August 1, 2021, lacked a signature or other authentication by the licensee and by the resident documenting agreement on the services to be provided. On February 2, 2022, at approximately 8:57 a.m. RN-B confirmed R1's service plans lacked the above signatures. The licensee's policy, Service Plan dated August 1, 2021, indicated all residents receiving assisted living services would have a service plan in place and indicated within 14 days after the date that services are first provided to a resident, the licensee would finalize a written service plan. The service plan and any revisions "shall include a signature or other authentication by [Name of AL] and by the resident, or resident's representative, documenting agreement on the services to be provided." No further information was provided.	01640		

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01640	Continued From page 85 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (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 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	01650		

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01650	Continued From page 86	01650		

plan included all required content for one of one resident (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), 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's Service Plan dated August 1, 2021, unsigned, indicated "Services Provided" were bathing assistance, bathing reminder, behavior management (anxiety, repetitive, self injury, self isolation, sexual inappropriateness, verbal aggression), manage symptoms (depression, wandering, other mental health need), dressing a.m., drinking assistance, housekeeping, laundry, linen change, meal assistance, meal reminder, medication administration, nail care, record blood glucose, record blood pressure, record pulse, remove garbage, skin care, socialization, therapeutic exercises, shopping assistance as needed and symptom screen. The service plan also identified the staff categories of who would provide the services and frequency of service.

On February 1, 2022, at 7:31 a.m. unlicensed personnel (ULP)-C was observed to check R1's blood pressure, pulse, blood sugar and administer medications to R1. At 7:52 a.m., registered nurse (RN)-B was observed to set up medications into a weekly pill box for the dates of February 1 through February 8, 2022. During that time, R1 was observed to be walking up and down the hallway and licensed assisted living

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01650	Continued From page 87 director (LALD)-A stated R1 had a foot amputation and the shoes R1 was wearing helped R1 walk better. R1's record identified an order dated June 2, 2021, for "prescribed footwear. Prosthetic shoe is being used as an integral part of prosthesis for a partial foot amputation. The date of the surgery was greater than 2 years (unknown date) at another institution. He requires this orthosis/device for the bilateral side of the body. He has left transmetatarsal amputation". In addition, the service plan indicated for "Contingency Plan: Essential Services: If services are needed for medical or safety reasons and facility are unable to keep the service, we will make arrangements for services to be provided through an outside provider or other means,which may include your transfer to another facility, agency, and or acute care setting". R1's Service Plan dated August 1, 2021, lacked the service of medication set up by the RN, prosthetic shoe treatment services, identification of staff who would provide the services, frequency of the services and lacked the fee for all services mentioned above. In addition, the contingency plan failed to address how "arrangements for services to be provided through an outside provider or other means" would be done or who the provider would be. On February 2, 2022, at approximately 8:57 a.m. RN-B confirmed R1's service plan lacked the above content. RN-B confirmed all resident service plans would lack the same information from the contingency plan. The licensee's policy, Service Plan dated August	01650		

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01650	Continued From page 88 1, 2021, indicated a service plan would include a description of the services that are to be provided based on the most recent assessment and resident preferences, fees for services to be provided, the frequency of each service to be provided based on the most recent assessment and resident preferences, an identification of staff or categories of staff who will be providing services, a contingency plan that includes actions the licensee would take if the scheduled services could not be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent	01700		

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diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure an assessment for self administration of medication for one of one resident (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 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:

The licensee lacked a self-administration of medication assessment by the registered nurse (RN) for safety of self administration of Tums (used to relieve heartburn) medication.

R1's diagnoses included, but were not limited to, dementia and diabetes.

R1's Service Plan dated August 1, 2021, unsigned, indicated "Services Provided" included,

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01700	Continued From page 90 but were not limited to, medication administration. On February 1, 2022, at 7:31 a.m. unlicensed personnel (ULP)-C was observed to check R1's blood pressure, pulse, blood sugar and administer medications to R1. R1's MD (doctor of medicine) orders dated January 4, 2022, included, but were not limited to, an order for Tums 500 milligrams as needed, may keep in room and take as needed. R1's Assessment dated November 23, 2021, indicated "Self-Admin [administration] of Meds [medication] Med Self-Admin is not applicable Only takes Tums by himself as needed". R1's record lacked a comprehensive assessment for medication self-administration by the RN for the safety of R1 self-administering Tums as needed. On February 2, 2022, at 8:57 a.m. RN-B confirmed R1's record lacked a comprehensive assessment for self-administration of medication as above. A Medication Assessment for Safety in Self-Administration sample form, undated, was included with policies the licensee provided. The licensee's policy, Medication Management Assessment, Monitoring and Reassessment dated August 1, 2021, indicated prior to providing medication management services, the licensee would have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. The policy did not	01700		

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01700	Continued From page 91 address self-administration of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used	01790		

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01790	Continued From page 92 for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. 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) developed written procedures for unplanned time away from home. In addition, the licensee failed to ensure two of two unlicensed personnel (ULP-C, ULP-D) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away with records	01790		

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01790	Continued From page 93 reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: UNPLANNED TIMES AWAY PROCEDURE FOR ULP The licensee failed to develop and implement a written procedure for the ULP providing medications for clients having unplanned times away. The licensee's policy Medication Management Planned and Unplanned Time Away dated August 1, 2021, indicated "for unplanned resident time away when a pharmacist or licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: The registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident". The licensee lacked a written procedure as required which addressed: -the type of container or containers to be used for the medications appropriate to the provider's medication system; -how the container or containers must be labeled; -written information about the medications to be provided; -how the unlicensed staff must document in the	01790		

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01790	Continued From page 94	01790		

resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;
-how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;
-a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and
-how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.

TRAINING AND COMPETENCY EVALUATIONS
ULP-C had a hire date of December 27, 2021.

On February 1, 2022, at 7:31 a.m. ULP-C was observed to check R1's blood pressure, pulse, blood sugar and administer medications to R1.

ULP-D had a hire date of August 5, 2021.

ULP-C and ULP-D's records lacked evidence to indicate the RN provided training and determined competency to prepare and administer medications to residents for unplanned times away.

On January 31, 2022, at 1:32 p.m. RN-B confirmed the licensee's ULP could prepare and send medications with the resident or the

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01790	Continued From page 95 resident's responsible person, according to the licensee's policy and procedure. RN-B verified ULP-C and ULP-D administered medications, but were not trained and had not demonstrated competency to prepare or give medications for any of the licensee's residents for unplanned times away. RN-B stated, "I don't have that," in regards to a written procedure as indicated above. RN-B further confirmed all employees would lack the same. The licensee's policy, Medication Management Planned and Unplanned Time Away dated August 1, 2021, indicated for unplanned resident time away when a pharmacist or licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure access to	01880		

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01880	Continued From page 96	01880		

keys for medication storage was secure. 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:

On February 1, 2022, at 7:31 a.m. unlicensed personnel (ULP)-C was observed to place the keys used to unlock a closet area where resident medications were stored, into an unlocked upper cupboard above the microwave in the kitchen. The cupboard could be accessed by all residents and any visitors. At 8:28 a.m., registered nurse (RN)-B verified the cupboard was not secure and any person would have access to the keys used to unlock the closet area, where the residents medications were stored.

The licensee's policy, Medication Storage dated August 1, 2021, indicated when medications are managed and stored by the licensee, medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications. Medications managed by the licensee would be stored to prevent diversion of medications by residents or others who may have access to the medications. Medications managed outside of a resident's private "living space" would be in a securely locked and substantially constructed compartments and "permit only authorized personnel to have access. This may be a

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01880	Continued From page 97 medication room, medication cart, or similar setup". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 98 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 include in the service plan a written statement of the treatment or therapy services that would be provided, and develop and maintain a current individualized treatment and therapy management record for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's service plan lacked the treatment or therapy service of a prosthetic shoe, and lacked an individualized treatment and therapy management record for management of prescribed treatments or therapy services. R1's MD (doctor of medicine) orders dated January 4, 2022, indicated "Services" included, but were not limited to, record blood glucose two times per day and therapeutic exercises daily. R1's record identified an order dated June 2, 2021, for "prescribed footwear. Prosthetic shoe is being used as an integral part of prosthesis for a partial foot amputation. The date of the surgery	01940		

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01940	Continued From page 99	01940		

was greater than 2 years (unknown date) at another institution. He requires this orthosis/device for the bilateral side of the body. He has left transmetatarsal amputation".

On February 1, 2022, at 7:31 a.m. unlicensed personnel (ULP)-C was observed to check R1's blood sugar. At 7:52 a.m., registered nurse (RN)-B was observed to set up medications into a weekly pill box for the dates of February 1 through February 8, 2022. During that time, R1 was observed to walk up and down the hallway. Licensed assisted living director (LALD)-A stated R1 had a foot amputation, and the shoes R1 was wearing helped R1 walk better. RN-B also stated ULP-C would help R1 with range of motion (ROM) exercises.

R1's Service Plan dated August 1, 2021, unsigned, indicated "Services Provided" included, but were not limited to, record blood glucose and therapeutic exercises. The service plan lacked the treatment or therapy service of a prosthetic shoe.

R1's record lacked an individualized treatment and therapy management record to contain the following:
-a statement of the type of services that will be provided;
-documentation of specific resident instructions relating to the treatments 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 treatments or therapy services; and
-any resident-specific requirements relating to

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01940	Continued From page 100 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 be current and updated when there are any changes. On February 2, 2022, at approximately 8:57 a.m. RN-B verified R1 received the treatment and therapies noted above. RN-B confirmed R1's service plan lacked the treatment or therapy service of prosthetic shoe, and R1 lacked an individualized treatment and therapy management record. The licensee's policy, Treatment & Therapy Management Plan dated August 1, 2021, indicated for each resident receiving management of ordered or prescribed treatments or therapy services, the facility would prepare and include in the service plan a written statement of the treatment or therapy services that would be provided to the resident and would develop and maintain a current individualized treatment and therapy management record to contain the above content as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or	01950		

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01950	Continued From page 101 other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for one of one resident (R1) and two of two unlicensed personnel (ULP-C, ULP-D) were instructed in the proper methods and had demonstrated the ability to competently follow the procedures, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	01950		

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01950	Continued From page 102 of the residents). The findings include: R1's record lacked in writing, specific instructions for the treatment or therapy services of blood sugar checks, prosthetic shoe and therapeutic exercises. In addition, the RN had not trained and competency evaluated ULP for the treatment and therapy management services of blood sugar check, prosthetic shoe and therapeutic exercises. R1's Service Plan dated August 1, 2021, unsigned, indicated "Services Provided" included, but not limited to, record blood glucose and therapeutic exercises. The service plan lacked the treatment or therapy service of prosthetic shoe. R1's MD (doctor of medicine) orders dated January 4, 2022, indicated "Services" included, but were not limited to, record blood glucose two times per day and therapeutic exercises daily. R1's record identified an order dated June 2, 2021, for "prescribed footwear. Prosthetic shoe is being used as an integral part of prosthesis for a partial foot amputation. The date of the surgery was greater than 2 years (unknown date) at another institution. He requires this orthosis/device for the bilateral side of the body. He has left transmetatarsal amputation". On February 1, 2022, at 7:31 a.m. ULP-C was observed to check R1's blood sugar. At 7:52 a.m., R1 was observed to be walking up and down the hallway. Licensed assisted living director (LALD)-A stated R1 had a foot amputation and the shoes R1 was wearing helped R1 walk better. RN-B further stated	01950		

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01950	Continued From page 103 ULP-C would also assist R1 with range of motion (ROM) exercises. ULP-C had a hire date of December 27, 2021. ULP-D had a hire date of August 5, 2021. ULP-C and ULP-D's records lacked evidence of training and competency evaluation for the delegated treatment and therapy services of blood sugar checks, use of the prosthetic shoe, and ROM exercises for R1. On January 31, 2022, at approximately 12:48 p.m. RN-B stated she had trained ULP-C to check R1's blood sugar; however, RN-B verified ULP-C and ULP-D's records lacked documented training and competency evaluation for the blood sugar check. RN-B also verified R1's record lacked a written procedure for the blood sugar check and stated she would have to write up the procedure and train and competency the ULP on the procedure. RN-B stated all ULP records would lack the documented training and competency for a blood sugar check. On February 2, 2022, at approximately 8:57 a.m. RN-B verified R1 was receiving all the treatment and therapies listed above, and the treatment and therapy services were prescribed and had been delegated to ULP. RN-B further confirmed R1's record lacked specific written instructions for the prosthetic shoe and ROM exercises. The licensee's policy, Medication & Treatment Administration and Delegation dated August 1, 2021, indicated when administration of treatment/therapy is delegated or assigned to unlicensed personnel, the licensee would ensure the RN had instructed the ULP in the proper	01950		

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01950	Continued From page 104 methods with respect to each resident to administer or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures and had specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure documentation and administration of treatment as prescribed for one of one resident (R1) 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	01960		

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01960	Continued From page 105	01960		

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 record lacked evidence of documentation for the treatment of prescribed prosthetic shoe.

R1's Service Plan dated August 1, 2021, unsigned, indicated "Services Provided" included, but were not limited to, record blood glucose and therapeutic exercises. The service plan lacked the treatment or therapy service of a prosthetic shoe.

R1's record identified an order dated June 2, 2021, for "prescribed footwear. Prosthetic shoe is being used as an integral part of prosthesis for a partial foot amputation. The date of the surgery was greater than 2 years (unknown date) at another institution. He requires this orthosis/device for the bilateral side of the body. He has left transmetatarsal amputation".

On February 1, 2022, at 7:31 a.m. unlicensed personnel (ULP)-C was observed to check R1's blood sugar. At 7:52 a.m., R1 was observed to walk up and down the hallway. Licensed assisted living director (LALD)-A stated R1 had a foot amputation and the shoes R1 was wearing helped R1 walk better.

R1's Service Recap Summary dated January 2022, lacked documentation for assisting with treatment and therapy service of a prosthetic shoe.

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01960	Continued From page 106 On February 2, 2022, at 1:40 p.m. registered nurse (RN)-B confirmed ULP provided the prescribed treatment service of a prosthetic shoe, and R1's record lacked documentation of the person who administered the treatment or therapy, including the date and time of administration. The licensee's policy, Medication and Treatment Record Documentation and Refusal dated August 1, 2021, indicated documentation of treatment/therapy records would include documentation of the person who administered the treatment or therapy, including the date and time of administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure there were current treatment and therapy orders that	01970		

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01970	Continued From page 107 included the frequency, duration, and other required information needed for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's MD (doctor of medicine) orders dated January 4, 2022, indicated "Services" included, but were not limited to, therapeutic exercises daily. On February 1, 2022, at 7:52 a.m. R1 was observed to be walking up and down the hallway and registered nurse (RN)-B stated unlicensed personnel (ULP)-C assisted R1 with range of motion (ROM) exercises. R1's Service Recap Summary dated January 2022, indicated staff documented for providing therapeutic exercises every a.m. R1's MD order for "therapeutic exercises" lacked a description of the exercises to be provided and the duration. On February 2, 2022, at approximately 8:57 a.m. licensed assisted living director (LALD)-A stated the ULP provided ROM exercises for legs and arms when sitting and wall exercises when standing. RN-B verified R1's MD order lacked a	01970		

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01970	Continued From page 108 description of the exercises to be provided and duration for the prescribed therapeutic exercises daily. The licensee's policy, Medication and Treatment Orders dated August 1, 2021, indicated an order for a treatment "must contain" the name of the resident, a description of the treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
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 interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors.	02040		

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02040	Continued From page 109 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 residents). The findings include: A review of the Hazard Vulnerability Assessment showed global issues such as fire, gas leak, epidemic, and shooter had been identified. Mitigation procedures had not been developed. Local hazards that are site, building and population-specific had not been developed. During the interview on January 31, 2022, at 11:40 a.m. licensed assisted living director (LALD)-A stated he had not done a review of the site, building, and population to identify any hazards to the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's	02110		

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02110	Continued From page 110 values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02110		

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02110	Continued From page 111 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 included: R1's record included no documentation for receipt of required policies and procedures to be provided at the time of resident move-in to the facility. The licensee's Assisted Living with Dementia Care Additional Required Policies dated August 1, 2021, identified because the licensee "has an Assisted Living with Dementia Care license, in addition to the policies and procedures required for the facility written policies and procedures must address the following list. In addition, these policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. The policies can be provided in electronic format if desired." -"Philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; -Evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; -Wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -Description of life enrichment programs and how activities are implemented; -Description of family support programs and	02110		

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02110	Continued From page 112 efforts to keep the family engaged; -Limiting the use of public address and intercom systems for emergencies and evacuation drills only; -Transportation coordination and assistance to and from outside medical appointments; -Safekeeping of residents' possessions." On February 2, 2022, at approximately 12:13 p.m. licensed assisted living director (LALD)-A confirmed the above policies lacked documented information, which was required to be addressed by the licensee. LALD-A confirmed he had not provided the policies and procedures to the residents and the residents' legal and designated representatives. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
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 designate a qualified person to	02140		

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02140	Continued From page 113	02140		

oversee staff training in the care of individuals with dementia. 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

RN-B's employee record included, but was not limited to, Assisted Living Minnesota Orientation Checklist and Requirements sheets for Educare training topics, which had a created date by Educare of July 31, 2019. The sheets identified the "subject matter" for dementia training was "dementia training for memory care providers" for housing with services (HWS) establishments and arranged home care providers in HWS settings; and the topics were explanation of Alzheimer's disease and other dementia's, assistance with activities of daily living, problem solving with challenging behaviors and communication skills. RN-B signed the Assisted Living Minnesota Orientation Checklist and Requirements sheets, but there was no date for the signature. In addition, RN-B's employee record included Tally of Education by Individual Employee for calendar year 2020 sheet, which identified "Dementia and Alzheimer's Training" date of December 1, 2020, a total of six hours (videos per interview above), but it did not indicate what topics were viewed by video for dementia training. RN-B's record lacked evidence of any approved competency or knowledge test required for supervising staff in an

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02140	Continued From page 114 assisted living facility with dementia care. On January 31, 2022, at 11:42 a.m. RN-B stated she provided supervision of unlicensed staff, including training. RN-B stated she had training of dementia topics by videos and reading information through Educare (innovative training solutions), which all staff completed for dementia training. RN-B stated she has had 25 years of work experience in home care and assisted living. At 12:48 p.m., RN-B stated she had not completed any approved competency or knowledge test required for supervising staff in an assisted living facility with dementia care. RN-B verified she was unaware of the requirement. On January 31, 2022, at 11:50 a.m. licensed assisted living director (LALD)-A stated the licensee did not do online training for Educare, but used Educare training materials which were completed in person with staff. The licensee's policy, ALDC (assisted living dementia care) Additional Dementia Staff Training dated August 1, 2022, indicated staff who work with residents with Alzheimer's disease and other dementia's would have proper training for the tasks assigned and the persons conducting such training will be qualified to train in the care of individuals with dementia. Qualification would include the following: has completed and passed training approved by Minnesota Department of Health (MDH). No further information was provided. TIME PERIOD TO CORRECT: Fourteen (14) day	02140		

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02170	Continued From page 115	02170		
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 that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities.	02170		

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02170	Continued From page 116 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure evaluation for activities for one of one resident (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), 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: The facility had an assisted living with dementia care (ALFDC) license, effective August 1, 2021. R1's diagnoses included, but were not limited to, dementia. R1's record lacked an evaluation for activities addressing 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 R1's record identified an Individualized Activity Plan dated November 23, 2021; however, the plan was developed prior to an evaluation of activities as above.	02170		

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02170	Continued From page 117 R1's Master Care Plan dated December 20, 2021, indicated "activity capabilities needs cueing to participate in activities. Note: need to encourage to socialize and get involved activities". Spiritual/cultural traditions were religion "Muslim" and significant spiritual traditions was "prayer" five times a day. There was no other documented information for activities on R1's care plan. In addition, R1's record lacked documentation of a selection of daily structured and non-structured activities being provided and included on the R1's activity service or care plan. On February 2, 2022, at approximately 8:57 a.m. registered nurse (RN)-B confirmed an activity evaluation had not been completed for R1. RN-B confirmed a selection of daily structured and non-structured activities was not documented in R1's record. RN-B at the time was informed of the evaluation for activities in RTasks (computer system utilized by the licensee) via phone with an RTasks person; therefore, all residents would lack an evaluation for activities. The licensee's policy, ALDC Life Enrichment Programs, Activities and Outdoor Space dated August 1, 2021, indicated each resident must be evaluated for activities according to the licensing rules of the facility. The policy further indicated the evaluation must address the above as required and 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 and 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".	02170		

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02170	Continued From page 118 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02180 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Access to secured outdoor space and walkways that allow residents to enter and return without staff assistance must be provided. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure behavioral symptoms identified were addressed on the care plan for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	02180		

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	34623	A. BUILDING: _____ B. WING _____	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBLAND HOME HEALTH CARE	963 21ST STREET SE ROCHESTER, MN 55904

(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
02180	Continued From page 119 The findings include: The licensee had an assisted living with dementia care (ALFDC) license, effective August 1, 2021. R1's diagnoses included, but were not limited to, dementia. R1's Behavior Plan Assessed Needs and Services as of January 31, 2022, identified the following behaviors/mental illness: hoarding (towels, uses to wipe bottom and will hide soiled towels in room) depression (regret regarding past life, alcoholism, homeless in past, loss vision, not able to have a car), delusions (sometimes sees people who are not there and talks to them, stated he has seen the devil in the trees in the backyard) and post-traumatic stress disorder (related to being assaulted in the past and sustaining a head injury resulting in traumatic brain injury). The Behavior Plan lacked interventions to minimize the behaviors/mental illness for staff to implement. On February 2, 2022, at approximately 8:57 a.m. registered nurse (RN)-B confirmed R1's Behavior Plan lacked interventions to minimize the above behaviors/mental illness for staff to implement. The licensee's policy, ALDC Behavioral Symptoms, Interventions and Nonpharmacological Approaches dated August 1, 2021, indicated as an Assisted Living with Dementia Care licensed facility, the licensee supports person-centered and evidence-based evaluation of behavioral symptoms and design of supports for intervention plans; including nonpharmacological interventions or practices.	02180		

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02180	Continued From page 120 The licensee would identify behavioral symptoms that negatively impact other residents and others in the assisted living facility and evaluate to determine potential interventions to minimize such behaviors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02180		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34623	A. BUILDING: _____ B. WING _____	02/02/2022

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ROBLAND HOME HEALTH CARE	963 21ST STREET SE ROCHESTER, MN 55904

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02240	Continued From page 121 address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for one of one resident (R1) with record reviewed. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34623	A. BUILDING: _____ B. WING _____	02/02/2022

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ROBLAND HOME HEALTH CARE	963 21ST STREET SE ROCHESTER, MN 55904

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02240	Continued From page 122 R1 began receiving assisted living services on August 1, 2021. On February 1, 2022, at 12:35 p.m. licensed assisted living director (LALD)-A stated registered nurse (RN)-B provided the Bill of Rights to the licensee residents. R1's record indicated on February 20, 2020, R1 had received a copy of the "home care bill of right". The copy of the Home Care Bill of Rights in R1's record was titled "Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers" dated November 2019. An Admission Process checklist dated August 1, 2021, indicated "give resident/representatives copy of: Assisted living Bill of Rights" and included with the information was a copy titled "Minnesota Home Care Bill of Rights". There was no written acknowledgment from the resident of the resident's receipt. R1's record further indicated R1 had signed for "Receipt" of the statute "144G.91 Assisted Living Bill of Rights" subdivision 1 through subdivision 26 (copy of statute); however, R1's record lacked evidence the resident had received the Assisted Living Bill of Rights dated May 16, 2021. On February 2, 2022, at 9:38 a.m. registered nurse (RN)-B confirmed the current residents did not have a signed acknowledgement of receiving the current Assisted Living Bill of Rights dated May 16, 2021, and she had not provided the information to the residents. The licensee's policy, Protecting Resident Rights dated August 1, 2021, indicated "Prior to, or at the	02240		

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	34623	A. BUILDING: _____ B. WING _____	02/02/2022

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02240	Continued From page 123 time of admission, all residents will be provided a copy of the Minnesota Assisted Living Bill of Rights". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered 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).	02260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34623	A. BUILDING: _____ B. WING _____	02/02/2022

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ROBLAND HOME HEALTH CARE	963 21ST STREET SE ROCHESTER, MN 55904

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02260	Continued From page 124 The findings include: The licensee's policy, ALDC (assisted living dementia care) Notice of Dementia Training dated August 1, 2021, indicated "As an assisted living with dementia care license, Robland home health care will make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request". The policy further indicated "1. [FACILITY NEEDS TO OUTLINE WHAT'S INCLUDED IN YOUR NOTICE]". The licensee lacked description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. On February 1, 2022, at 12:42 p.m. licensed assisted living director (LALD)-A stated the licensee would provide to residents, families or other persons who requested the licensee's ALDC Notice of Dementia Training dated August 1, 2021, as the licensee's written or electronic form for a description of the training program and related training it provided, including the categories of employees trained, the frequency of training, and the basic topics covered notice. LALD-A confirmed the policy was not addressed by the licensee regarding the content for notice. No further information was provided. TIME PERIOD FOR CORRECTION:	02260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02260	Continued From page 125 Twenty-One (21) days	02260		
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 the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 31, 2022, at approximately 9:33 a.m. upon arriving at the establishment, an observation outside the front entrance, or just	03090		

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03090	Continued From page 126 inside the front entrance, lacked the required posting for electronic monitoring devices. During the entrance conference on January 31, 2022, at approximately 9:56 a.m. licensed assisted living director (LALD)-A verified the licensee had no posting at the facility entrance for electronic monitoring as required. The licensee's policy, Electronic Monitoring dated August 1, 2021, indicated "Signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

DEPARTMENT OF HEALTH

Type: Full
Date: *01/31/22*
Time: 10:18:21
Report: 7920221013

Food and Beverage Establishment Inspection Report

Location:
Robland Home Health Care
963 21st Street Se
Rochester, MN55904
Olmsted County, 55

Establishment Info:
ID #: 0038367
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072524619
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.

Food and Equipment Temperatures

Process/Item: Refrigerator
Temperature: 39 Degrees Fahrenheit - Location: Fruit, vegetables, eggs, left-over foods
Violation Issued: No

Process/Item: Freezer
Temperature: 0 Degrees Fahrenheit - Location: Vegetables, breakfast foods.
Violation Issued: No

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

I acknowledge receipt of the inspection report number 7920221013 of 01/31/22.

Certified Food Protection Manager Omar S Hassan

Certification Number: FM108411 Expires: 09/11/24

Signed: _____
Establishment Representative

Signed: 
Sam Boysen
Public Health Sanitarian
Rochester District Office
507-206-2719
samuel.boysen@state.mn.us

Report #: 7920221013

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	0	**Date**	01/31/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	10:18:21
Legal Authority MN Rules Chapter 4626		**Time Out**	

Robland Home Health Care	**Address** 963 21st Street Se	**City/State** Rochester, MN	**Zip Code** 55904	**Telephone** 5072524619
License/Permit # 0038367	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT — PIC knowledgeable; duties & oversight		
2	IN OUT N/A — Certified food protection manager, duties		
Employee Health			
3	IN OUT — Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT — Proper use of reporting, restriction & exclusion		
5	IN OUT — Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6	IN OUT N/O — Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O — No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8	IN OUT N/O — Hands clean & properly washed		
9	IN OUT N/A N/O — No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT — Adequate handwashing sinks supplied/accessible		
Approved Source			
11	IN OUT — Food obtained from approved source		
12	IN OUT N/A N/O — Food received at proper temperature		
13	IN OUT — Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O — Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15	IN OUT N/A N/O — Food separated and protected		
16	IN OUT N/A — Food contact surfaces: cleaned & sanitized		
17	IN OUT — Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O — Proper cooking time & temperature		
19	IN OUT N/A N/O — Proper reheating procedures for hot holding		
20	IN OUT N/A N/O — Proper cooling time & temperature		
21	IN OUT N/A N/O — Proper hot holding temperatures		
22	IN OUT N/A — Proper cold holding temperatures		
23	IN OUT N/A N/O — Proper date marking & disposition		
24	IN OUT N/A N/O — Time as a public health control: procedures & records		
Consumer Advisory			
25	IN OUT N/A — Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26	IN OUT N/A — Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A — Food additives: approved & properly used		
28	IN OUT — Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29	IN OUT N/A — Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

		COS	R
Safe Food and Water			
30	IN OUT N/A — Pasteurized eggs used where required		
31	Water & ice obtained from an approved source		
32	IN OUT N/A — Variance obtained for specialized processing methods		
Food Temperature Control			
33	Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O — Plant food properly cooked for hot holding		
35	IN OUT N/A N/O — Approved thawing methods used		
36	Thermometers provided & accurate		
Food Identification			
37	Food properly labled; original container		
Prevention of Food Contamination			
38	Insects, rodents, & animals not present		
39	Contamination prevented during food prep, storage & display		
40	Personal cleanliness		
41	Wiping cloths: properly used & stored		
42	Washing fruits & vegetables		

		COS	R
Proper Use of Utensils			
43	In-use utensils: properly stored		
44	Utensils, equipment & linens: properly stored, dried, & handled		
45	Single-use/single service articles: properly stored & used		
46	Gloves used properly		
Utensil Equipment and Vending			
47	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	Warewashing facilities: installed, maintained, & used; test strips		
49	Non-food contact surfaces clean		
Physical Facilities			
50	Hot & cold water available; adequate pressure		
51	Plumbing installed; proper backflow devices		
52	Sewage & waste water properly disposed		
53	Toilet facilities: properly constructed, supplied, & cleaned		
54	Garbage & refuse properly disposed; facilities maintained		
55	Physical facilities installed, maintained, & clean		
56	Adequate ventilation & lighting; designated areas used		
57	Compliance with MCIAA		
58	Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 01/31/22

Inspector (Signature)