Electronically Delivered

June 10, 2022

Administrator
Hills Crossing Senior Living
5307 Hills Crossing
Nisswa, MN 56468

RE: Project Number SL27831015

Dear Administrator:

On June 1, 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 March 16, 2022. The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the March 16, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on March 16, 2022, found not corrected at the time of the June 1, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0490-Minimum Requirements-144g.41 Subd 1 (13) (ii)-(vii) - $500.00
0510-Infection Control Program-144g.41 Subd. 3 - $500.00
0950-Designation Of Representative-144.50 Subd. 3
1370-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (a)
1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4
2170-Services For Residents With Dementia-144g.84 - $500.00

The details of the violations noted at the time of this follow-up evaluation completed on June 1, 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 $1,500.00**. 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 Jessie Chenze at 218-332-5175.

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,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27831	A. BUILDING: _____ B. WING _____	R 06/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLS CROSSING SENIOR LIVING	5307 HILLS CROSSING NISSWA, MN 56468

(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 # SL27831015-1 On May 31, 2022, through June 1, 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 March 16, 2022. At the time of the survey, there were 22 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.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{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 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	{0 490}		

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{0 490}	Continued From page 2 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 interview and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all 22 residents of 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: During the entrance conference on May 31, 2022, at 9:25 a.m., the surveyor asked for the licensee's daily activity calendar, which was provided to and later reviewed by the surveyor. The May 2022, "Activity Calendar" included at least one scheduled activity for the memory care unit and assisted living unit daily except for on Saturdays, Sundays, and the Memorial Day	{0 490}		

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{0 490}	Continued From page 3 holiday. On May 31, 2022, at 1:05 p.m., activity director (AD)-K confirmed there were not scheduled activities for either the memory care unit or assisted living unit on weekends or on the Memorial Day holiday. AD-K stated the staff on the units are supposed to conduct an activity with the residents on the weekends and document the activity in the electronic record. AD-K stated she does not monitor if activities are being done when they are not scheduled. The surveyor asked for the electronic May 2022, activity log which was later provided by unlicensed personnel (ULP)-C. The May 2022, activity documentation for the weekends and holiday revealed the following: - for the memory care unit activities had not been provided four out of ten opportunities - for the assisted living unit activities had not been provided nine out of ten opportunities On May 31, 2022, at 4:40 p.m., AD-K stated the licensee was not providing a daily activity program as activities were not being consistently provided on weekends and holidays. The licensee's undated Activity Calendar policy indicated activities should contain sufficient variety so that all residents have at least one meaningful contact each day, including weekends. No further information was provided.	{0 490}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	{0 510}		

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{0 510}	Continued From page 4	{0 510}		

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 effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19 regarding wearing appropriate personal protective equipment (PPE). This had the potential to affect all 22 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:

The Minnesota Department of Health (MDH) guidance titled, COVID-19 Personal Protective Equipment (PPE) and Source Control Grids dated April 7, 2022, indicated health care workers

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{0 510}	Continued From page 5	{0 510}		

working with residents with or without suspected or confirmed SARS-CoV-2 (Covid-19) wear a face mask and eye protection in communities with substantial and high community transmission levels.

On May 31, 2022, at 9:21 a.m., the surveyor observed upon entrance to the facility unlicensed personnel (ULP)-C not wearing eye protection.

On May 31, 2022, at 11:51 a.m., the surveyor observed ULP-G to assist R4 from her bed to the bathroom using a gait belt and stand by assist. ULP-G provided toileting assist and escorted R4 back to a chair in R4's room. The surveyor observed ULP-G, using appropriate technique, to monitor R4's blood glucose level and administered R4's scheduled insulin. The surveyor observed ULP-G to not be wearing eye protection during the above noted observations.

On May 31, 2022, at 12:11 p.m., ULP-G stated she forgot to put on her eye protection today and had left it in her car.

On May 31, 2022, at 12:14 p.m., the surveyor observed ULP-F to transport R11 from the dining room to R11's room so R11 could wash her hands before lunch. ULP-F transported R11 back to the dining room and proceeded to start to serve lunch to residents seated at the dining room tables. The surveyor observed ULP-F to not be wearing eye protection during the above noted observations.

On May 31, 2022, at 12:23 p.m., ULP-F stated she was unsure if she should be wearing eye protection or not.

On May 31, 2022, at 12:40 p.m., registered nurse

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{0 510}	Continued From page 6 (RN)-A stated it was the licensee's expectations that staff follow the current MDH and Center for Disease Control and Prevention (CDC) guidelines with regards to PPE usage. RN-A stated she was aware of the PPE grid [referenced above]. At 1:35 p.m., RN-A verified their county's transmission level was high, so according to the licensee's policy and the reference noted above staff should be wearing eye protection when working with residents with or without suspected or confirmed COVID-19. The licensee's undated Personal Protective Equipment Grid policy indicated staff should be wearing a face mask and eye protection when working with residents with or without suspected or confirmed COVID-19 when the community transmission level is high. No further information was provided.	{0 510}		
{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	{0 810}		

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{0 810}	Continued From page 7 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required	{0 810}		
{0 950} SS=C	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and	{0 950}		

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{0 950}	Continued From page 8 advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing for three of four residents (R1, R3, R4) 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 the potential to affect a large portion or all the residents). The findings include: R1 R1's service plan dated March 17, 2022, indicated the resident received services which included medication administration, grooming, dressing, housekeeping, transferring and	{0 950}		

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{0 950}	Continued From page 9 toileting. R3 R3's service plan dated September 27, 2021, indicated the resident received services which included medication administration, bathing, grooming, dressing, housekeeping, and toileting. R4 R4's service plan dated May 11, 2022, indicated the resident received services which included medication administration, bathing, grooming, dressing, toileting, and housekeeping. R1, R3, and R4's medical record included a Designated Representative Form which was left blank. On June 1, 2022, at 11:03 a.m., licensed assisted living director (LALD)-I stated R1, R3, and R4 had not been provided the opportunity to identify a designated representative. LALD-I stated he thought this had been completed by the previous LALD. The licensee's undated Signing a Resident Agreement policy indicated the resident shall be given the opportunity to complete a Designated Representative Form prior to signing a Resident Agreement. No further information was provided.	{0 950}		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following:	{01370}		

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{01370}	Continued From page 10 (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 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 interview and record review, the	{01370}		

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{01370}	Continued From page 11 licensee failed to ensure training and competency was completed for one of two employees, (unlicensed personnel (ULP)-E), to include all required content 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-E was hired December 8, 2021, to provide direct care and services to the licensee's residents. ULP-E's employee file lacked documentation of training and competency evaluations for the following topics: -training on the prevention of falls; -basic nutrition, meal preparation, food safety, and assistance with eating; -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; -awareness of confidentiality and privacy; and -understanding appropriate boundaries between staff and residents and the resident's family. On June 1, 2022, at 12:07 p.m., licensed assisted living director (LALD)-I stated the required training noted above had not been completed for ULP-E and that she had the classes assigned to her, but they were not yet completed.	{01370}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLS CROSSING SENIOR LIVING	5307 HILLS CROSSING NISSWA, MN 56468

(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
{01370}	Continued From page 12 The licensee's undated Training and Competency Evaluation of Unlicensed Staff indicated unlicensed staff would meet all orientation and training requirements and will be determined to be competent to perform all assigned tasks by the registered nurse or other licensed health professional before unlicensed personnel may provide any service to a home care client. No further information provided.	{01370}		
{01440} SS=E	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.	{01440}		

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{01440}	Continued From page 13 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 licensee for two of two unlicensed personnel (ULP)-E, ULP-J 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-E ULP-E was hired on December 8, 2021, to provide direct care services to residents of the facility. ULP-E's employee record lacked documentation of a registered nurse (RN) supervising ULP-E performing a delegated task within 30 days of beginning work with the licensee. ULP-J ULP-J was hired on January 31, 2022, to provide direct care services to residents of the facility. ULP-J's employee record lacked documentation of a RN supervising ULP-J performing a delegated task within 30 days of beginning work with the licensee.	{01440}		

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{01440}	Continued From page 14 On June 1, 2022, at 10:05 a.m., RN-A stated a 30-day supervision was not completed for ULP-E and ULP-J. RN-A stated she was not aware of this requirement. The licensee's undated Supervision of Licensed and Unlicensed Personnel indicated direct supervision of unlicensed staff performing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for the agency and has been trained and determined competent to perform all the tasks assigned. No further information was provided.	{01440}		
{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: No further action required.	{02040}		
{02170} SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA	{02170}		

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{02170}	Continued From page 15 (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the	{02170}		

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{02170}	Continued From page 16 licensee failed to have an evaluation for an activity plan for four of four residents (R1, R3, R4, R9) who received services under an assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. R1 R1's diagnoses included dementia, anemia, arthritis, and colostomy (an opening into the colon from the outside of the body which provides a new path for waste material to leave the body). R1's Activities assessment dated April 28, 2022, identified R1's past and current activity preferences. R3 R3's diagnoses included Alzheimer's, chronic right shoulder and low back pain, anxiety, hypertension (high blood pressure), and osteoarthritis. R3's Activities assessment dated April 29, 2022, identified R3's past and current activity preferences.	{02170}		

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{02170}	Continued From page 17 R4 R4's diagnoses included type two diabetes, compression fractures, and restless leg syndrome. R4's Activities assessment dated March 23, 2022, identified R4's past and current activity preferences. R9 R9's diagnoses included dementia, mood disorder and sleep disorder. R9's Activities assessment dated March 23, 2022, identified R9's past and current activity preferences. R1, R3, R4 and R9's Activities assessments noted above did not include the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R1, R3, R4 and R9's record lacked the development of an individualized activity plan. On May 31, 2022, at 4:01 p.m., registered nurse (RN)-A stated the licensee had not completed a comprehensive activity evaluation or developed an activity plan as required. RN-A stated what we have is very "basic." The licensee's undated Activity Assessments policy noted the activity coordinator would meet with each new resident within seven days after moving to the facility to determine the resident's	{02170}		

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{02170}	Continued From page 18 interests and abilities. No further information was provided.	{02170}		

Electronically Delivered

April 15, 2022

Administrator
Hills Crossing Senior Living
5307 Hills Crossing
Nisswa, MN 56468

RE: Project Number(s) SL27831015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 16, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statutes, Chapter 144A and/or Minn. Stat. § 626.5572 and/or Minn. Stat. 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 Home Care 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 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. § 144A.474, Subd. 11(a), 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 § 144A.475 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144A.475.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144A.475.

In accordance with Minn. Stat. § 144A.474, Subd. 11(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. Subd. 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. § 144A.474, Subd. 11(a)(6), 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. §§ 144A.43 to 144A.482, the following fines are assessed pursuant to this evaluation:

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144A.474, Subd. 8(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's client(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. § 144A.474, Subd. 12, 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 date.

A state licensing order under Minn. Stat. § 144A.44 Subd. 1(14), Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144A.474, subd. 11 (g), a home care 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. § 144A.475, subd 4 and subd. 7, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

Jessie Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jessica.Chenze@state.mn.us
Phone: 651-508-2791| Fax: 218-332-5196

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	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: SL27831015 On March 14, 2022, through March 16, 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 21 residents, all of whom received services, under the provider's Assisted Living with Dementia Care license. The immediate correction order(s) tag identification 2310, identified on March 15, 2022, has been corrected as of March 15, 2022. No further action required.	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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 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 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	0 250		

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0 250	Continued From page 2 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 interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 14, 2022, at approximately 10:40 a.m., licensed assisted living director (LALD)-B stated the licensee's employees in charge of the facility	0 250		

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0 250	Continued From page 3 were familiar with the assisted living regulations and the licensee provided medication and treatment management services. 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, 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. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets	0 250		

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0 250	Continued From page 4 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 this 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 or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 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	0 250		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLS CROSSING SENIOR LIVING	5307 HILLS CROSSING NISSWA, MN 56468

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0 250	Continued From page 5 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 and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by the authorized agent on May 19, 2021. The licensee had an assisted living with dementia care license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - infection control practices; - medication and treatment management; and - supervision of unlicensed personnel performing delegated tasks. On March 15, 2022, at approximately 10:00 a.m., LALD-B confirmed the licensee provided assisted living with dementia care services, but failed to develop and implement the corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0480, 0490, 0510, 0650, 0680, 0810, 0950, 0970, 1290, 1370, 1380, 1440, 1470, 1540, 1770, 1880, 1890, 1960, 2040, 2110, 2170, 2260,	0 250		

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0 250	Continued From page 6 and 2310, indicating 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a	0 480		

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0 480	Continued From page 7 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated March 14, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 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	0 490		

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0 490	Continued From page 8 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 daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all 21 residents of 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). Findings include: Observations on March 14 and 15, 2022, revealed no activities were planned or offered. Some residents remained in their room most of the day or were stationed in front of the television in the common area in the memory care unit. On March 15, 2022, at approximately 7:00 a.m., the surveyor requested a copy of the activities scheduled. Unlicensed personnel (ULP)-H stated they did not have an activity calendar. ULP-H stated they currently did not have an activity person, so the ULP were supposed to do activities with the residents, but they did not have	0 490		

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0 490	Continued From page 9 time to do this with all their other duties. ULP-H stated the best they can do is to have the residents watch movies. On March 15, 2022, at approximately 9:15 a.m., licensed assisted living director (LALD)-B confirmed the facility did not currently have a daily activity program developed. LALD-B stated they most recently hired a full-time activity person. The licensee's Activity Program policy, undated, noted activities would be scheduled on a regular basis to enrich the lives of the residents. The licensee's Activity Calendar policy, undated, noted monthly calendars would be distributed to all residents with the monthly newsletter and daily calendars would be posted on the white boards. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 510 SS=E	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.	0 510		

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0 510	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for two of two unlicensed personnel (ULP-C, ULP-G) during a dressing change for R1 and while testing blood glucose levels for R4 and R5. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C On March 15, 2022, at approximately 8:04 a.m., ULP-C was observed to conduct a dressing change on R1's abdominal wound. Upon entering R1's room ULP-C performed hand hygiene and donned a pair of gloves. ULP-C gathered and prepared the dressing supplies from R1's bathroom. ULP-C and ULP-H transferred R1 from the wheelchair to her bed and positioned R1 on her back. ULP-C exposed R1's abdomen and with gloved hands removed the abdominal dressing which exposed an abdominal wound measuring approximately four centimeters (cm) by 0.5 cm. Using the same gloved hands, ULP-C moistened a 4x4 gauze dressing with water, placed the moistened dressing in the open abdominal wound, placed a cut ABD pad (a highly	0 510		

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0 510	Continued From page 11	0 510		

absorbent dressing that provides padding and protection for large wounds) over the moistened gauze dressing, which was packed into the abdominal wound, and secured the ABD pad with tape. ULP-C gathered her supplies, removed her gloves, and performed hand hygiene.

On March 15, 2022, at approximately 8:20 a.m., directly following the above noted observation, ULP-C verified during the dressing change for R1, she had not removed her gloves, performed hand hygiene, and applied a new pair of gloves after removal of the old dressing, packing of the wound and application of the new dressing.

ULP-G
On March 15, 2022, at approximately 8:25 a.m., ULP-G was observed donning gloves in the central medication room and gathering supplies to check R5's blood sugar. ULP-G was observed using a finger prick method to draw blood to check R5's blood glucose. ULP-G wiped away the blood from R5's finger and removed the test strip from the machine. ULP-G did not remove her gloves or perform hand hygiene and left R5's room to check R4's blood sugar in that resident's room. ULP-G entered R4's room and did not perform hand hygiene or don new gloves. ULP-G was observed scanning R4's arm to check the resident's blood glucose level. ULP-G was observed leaving the room and shutting the door and did not remove her soiled gloves or perform hand hygiene until she returned to the central medication room.

On March 15, 2022, at approximately 9:25 a.m., registered nurse (RN)-A confirmed gloves should be changed, and hand hygiene performed in between tasks such as removal of a dressing, wound care treatment and application of a new

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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0 510	Continued From page 12 dressing and that hands should be washed, and gloves should be changed between residents. The licensee's Procedure for Using Gloves, undated, noted gloves are to be worn whenever there may be direct contact between the caregiver's hands, and blood, body fluids, secretions, feces, or contaminated items such as soiled linens or wound dressings. Staff should wash hands, apply gloves to both hands, complete the task and if gloves become torn or heavily soiled and additional tasks must be performed for the client, then change the gloves (washing hands before putting on new gloves and before starting the next task). Wash hands after removal of gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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;	0 650		

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0 650	Continued From page 13 (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 by: Based on interview, and record review, the licensee failed to ensure current employee records were maintained to include all required content for two of three employees (registered nurse (RN)-D, unlicensed personnel (ULP)-E) 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: RN-D RN-D was hired November 9, 2016, to provide	0 650		

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0 650	Continued From page 14 direct care and services to the licensee's residents and oversight of the licensee's employees under the comprehensive license and began providing services under the assisted living with dementia care license on August 1, 2021. RN-D's employee record lacked the following required content: -evidence of current RN licensure; and -documentation of annual performance reviews that identify areas of improvement needed and training needs. On March 15, 2022, RN-D's license was confirmed on the Minnesota Board of Nursing website. ULP-E ULP-E was hired December 8, 2021 to provide direct care and services to the licensee's residents. ULP-E's employee record lacked the following required content: -current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. On March 15, 2022, at approximately 1:30 p.m., licensed assisted living director (LALD)-B confirmed RN-D and ULP-E's employee files were missing some of the required content. The licensee's undated Personnel Files policy indicated the personnel record would contain evidence of current professional licensure, records of home care orientation, record of all required training for unlicensed personnel and competency determinations, record of required in-service education for all staff providing home	0 650		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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0 650	Continued From page 15 care services to clients, documentation of a completed background study, documentation that the employee is not on the OIG or MHCP exclusion list, TB screening results, results of supervisor observations, performance evaluations which identify areas of improvement needed and training needs, current job description, which includes qualifications, responsibilities, and identification of staff person providing supervision, and emergency and disaster training. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding 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	0 680		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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0 680	Continued From page 16 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 have a written emergency preparedness plan with all the required content as defined in Appendix Z, with record review. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 14, 2022, at approximately 10:45 a.m., the surveyor requested to view the licensee's emergency preparedness plan (EPP). The plan contained a binder of various emergency situations, including how staff should respond. The licensee's policies contained direction on making an emergency plan, and the policies listed various emergency situations (such as heat, several weather emergencies, emergency evacuations, plan activations); however, the procedures spelled out in the plan	0 680		

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0 680	Continued From page 17 were generic, lacking specificity to the licensee. The licensee's plan lacked the following required content: -an assessment of the at-risk population's needs; -a process for emergency preparedness (EPS) cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies and procedures, based on risk assessment, and additional policies individualized to the facility for: potential evacuation, sheltering in place, handling medical documents and how the facility will provide care under an 1135 waiver declared by the Secretary; -a plan for sheltering in place when not able to evacuate; -transfer agreements and/or contracts with other facilities/providers to receive residents in the event of evacuation or other limitations that would impact the continuity of services; and -a communication plan with the following required content: names and contact information for staff/entities providing services under an agreement, residents' physicians, other facilities, volunteers, federal, state, tribal, regional, and local emergency preparedness staff, state licensing and certification agency, Office of the State Long Term Care Ombudsman, other sources of assistance, a plan for communicating during an emergency, including primary and alternative means for communication, procedures for sharing medical information to maintain continuity of care; and procedures for sharing the emergency plan with family members and residents. On March 14, 2022, at approximately 12:45 p.m.,	0 680		

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0 680	Continued From page 18 licensed assisted living director (LALD)-B stated she was not familiar with Appendix Z and was not aware of all the required content for the emergency preparedness plan. LALD-B confirmed the licensee's emergency preparedness plan did not contain all the required content. The licensee's undated Emergency Preparedness Manual indicated each community would have an Emergency Preparedness Manual that is available to staff at all times. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 thereafter.	0 810		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLS CROSSING SENIOR LIVING	5307 HILLS CROSSING NISSWA, MN 56468

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0 810	Continued From page 19 (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 document review and interview, the licensee failed to provide the required plans and resident training for fire safety and evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 16, 2022, at approximately 11:30 a.m., the licensed assisted living director (LALD-A) provided documents for review. Documents were reviewed by survey staff on March 16, 2022, between 11:30 a.m. and 12:15 p.m. 1. The plans did not include the identification of unique or unusual resident needs for movement or evacuation.	0 810		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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0 810	Continued From page 20 2. Residents are trained on fire safety at orientation within 24 hours of accepatance into the assisted living facility. On March 16, 2022, between 12:25 p.m. and 12:40 p.m., the LALD-A confirmed during the interview that the licensee failed to identify unique or unusual resident needs for movement or evacuation within the plans and that the training frequency for residents was not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=E	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."	0 950		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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0 950	Continued From page 21 (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing for three of three residents (R1, R3, R4) 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's service plan dated August 1, 2021, indicated the resident received services which included medication administration, bathing, grooming, dressing, housekeeping and toileting. R3 R3's service plan dated September 27, 2021, indicated the resident received services which included medication management administration,	0 950		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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0 950	Continued From page 22 bathing, grooming, dressing, housekeeping, and toileting. R4 R4's service plan, dated October 26, 2021, indicated the resident recieved services which included medication management administration, bathing, grooming, dressing, and housekeeping. R1, R3, and R4's medical record included a Designated Representative Form which was left blank. On March 15, 2022, at approximately 1:37 p.m., licensed assisted living director (LALD)-B confirmed R1, R3, and R4 had not been provided the opportunity to identify a designated representative. On March 14, 2022, at approximately 11:00 a.m., the licensee's assisted living with dementia care licensing policies and procedures were requested from registered nurse (RN)-A and LALD-B. The policies and procedures provided did not include a policy regarding a designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor	0 970		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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0 970	Continued From page 23 include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On March 14, 2022, at approximately 11:30 a.m., the surveyor requested a copy of the licensee's contract. The contract included two clauses that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident. Page 16, section C, of the contract indicated the community was not liable to the resident or resident's guests for any injury, death, or property damage occurring in the apartment or on landlord's premises unless such injury, death, or property damage occurs as the result of landlord's own negligent acts or those of its employees or agents. The contract further indicated the landlord was not liable for any injury,	0 970		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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0 970	Continued From page 24 death or damage occurring as the result of the resident's receipt of health-related, supportive or other services from their party providers. By signing the agreement, the resident agreed to hold the landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the apartment or on landlord's premise. On March 15, 2022, at approximately 9:15 a.m., licensed assisted living director (LALD)-B confirmed the contract used for all residents contained language that would waive the facility's liability for health, safety, or personal property of a resident. A policy on content of assisted living contracts was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith	01290		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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01290	Continued From page 25 reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living with dementia care license for three of three employees (registered nurse (RN)-D, unlicensed personnel (ULP)-C, and ULP-E) 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: RN-D RN-D was hired November 9, 2016, to provide direct care and services to the licensee's residents and oversight of the licensee's employees under the comprehensive license and began providing services under the assisted living with dementia care license on August 1, 2021. RN-D's employee record contained a background study, submitted by a separate location operated by the licensee's owner, dated July 21, 2021. RN-D's employee record lacked evidence the licensee submitted a background study for their license.	01290		

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01290	Continued From page 26 ULP-C ULP-C was hired March 18, 2015, to provide direct care and services to the licensee's residents under the comprehensive license and began providing services under the assisted living with dementia care license on August 1, 2021. ULP-C's employee record contained a background study, submitted by a separate location operated by the licensee's owner, dated June 29, 2021. ULP-C's employee record lacked evidence the licensee submitted a background study for their license. ULP-E ULP-E was hired December 8, 2021, to provide direct care and services to the licensee's residents. ULP-E's employee record contained a background study, submitted by a separate location operated by the licensee's owner, dated December 6, 2021. ULP-E's employee record lacked evidence the licensee submitted a background study for their license. On March 15, 2022, at approximately 8:10 a.m., licensed assisted living director (LALD)-B confirmed the background studies were submitted under a different address but confirmed they were using the correct HFID (health facility identification) when running the background studies. The licensee's undated Reference and Background Checks policy indicated the licensee would conduct reference and background checks on all employees and would follow licensing standards of background studies.	01290		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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01290	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=D	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 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,	01370		

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01370	Continued From page 28 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 interview and record review, the licensee failed to ensure training and competency was completed for one of two employees, (unlicensed personnel (ULP)-E), to include all required content 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-E was hired December 8, 2021, to provide direct care and services to the licensee's residents. ULP-E's employee file lacked documentation of training and competency evaluations for the following topics: -training on the prevention of falls; -basic nutrition, meal preparation, food safety, and assistance with eating;	01370		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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01370	Continued From page 29 -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; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; and -awareness of commonly used health technology equipment and assistive devices. On March 15, 2022, at approximately 9:55 a.m., licensed assisted living director (LALD)-B confirmed the required training had not been completed for ULP-E and that she had the classes assigned to her but they were not yet completed. LALD-B stated they try getting their staff to understand why required training needs to be done but they had been struggling with getting them to complete it. The licensee's undated Training and Competency Evaluation of Unlicensed Staff indicated unlicensed staff would meet all orientation and training requirements and will be determined to be competent to perform all assigned tasks by the registered nurse or other licensed health professional before unlicensed personnel may provide any service to a home care client. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel	01380		

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01380	Continued From page 30 providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of two employees, (unlicensed personnel (ULP)-E), to include all required content 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-E was hired December 8, 2021, to provide direct care and services to the licensee's residents.	01380		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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01380	Continued From page 31 ULP-E's employee file lacked documentation of training and competency evaluations for the following topics: -recognizing physical, emotional, cognitive, and developmental needs of the resident, On March 15, 2022, at approximately 9:55 a.m., licensed assisted living director (LALD)-B confirmed the required training had not been completed for ULP-E and that she had the classes assigned to her but they were not yet completed. LALD-B stated they try getting their staff to understand why required training needs to be done but they had been struggling with getting them to complete it. The licensee's undated Training and Competency Evaluation of Unlicensed Staff indicated unlicensed staff would meet all orientation and training requirements and will be determined to be competent to perform all assigned tasks by the registered nurse or other licensed health professional before unlicensed personnel may provide any service to a home care client. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
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	01440		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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01440	Continued From page 32 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 licensee for one of one unlicensed personnel (ULP)-E 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 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-E was hired on December 8, 2021, to	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLS CROSSING SENIOR LIVING	5307 HILLS CROSSING NISSWA, MN 56468

(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
01440	Continued From page 33 provide direct care services to residents of the facility. ULP-E's employee record lacked documentation of a RN supervising ULP-E performing a delegated task within 30 days of beginning work with the licensee. On March 15, 2022, at approximately 1:30 p.m., licensed assisted living director (LALD)-B confirmed a 30 day supervision was not completed for ULP-E. The licensee's undated Supervision of Licensed and Unlicensed Personnel indicated direct supervision of unlicensed staff performing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for the agency and has been trained and determined competent to perform all the tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=D	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;	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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01470	Continued From page 34 (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 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	01470		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01470	Continued From page 35 (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 interview and record review, the licensee failed to ensure one of two employees (registered nurse (RN)-D) received orientation to assisted living facility licensing to include all the required topics 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 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: RN-D's employee record lacked evidence to indicate RN-D had received the required orientation. RN-D was hired November 9, 2016, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-D's record lacked the following required orientation content: -an overview of assisted living regulations; -an introduction and review of the facility's policies and procedures related to the provision of	01470		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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01470	Continued From page 36 assisted living services by the individual staff person; - handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -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; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On March 15, 2022, at approximately 7:55 a.m., licensed assisted living director (LALD)-B confirmed RN-D did not receive assisted living orientation and she wasn't aware all existing employees needed to complete it on August 1, 2021 and they had not completed orientation with RN-D since she only worked on call. The licensee's undated All Staff Orientation policy indicated all employees would complete an orientation to assisted living facility licensing	01470		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01470	Continued From page 37 requirements and regulations before providing services to residents. 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. 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 employees received the required amount of dementia care training in the required time frame for three of three employees (registered nurse (RN)-D, unlicensed personnel (ULP)-C, ULP-E) with records reviewed.	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01540	Continued From page 38 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 had a current assisted living facility with dementia care license. RN-D RN-D was hired November 9, 2016, to provide direct care and services to the licensee's residents and oversight of the licensee's employees under the comprehensive license and began providing services under the assisted living with dementia care license on August 1, 2021. RN-D's employee record indicated she had not completed any required dementia training. ULP-C ULP-C was hired March 18, 2015, to provide direct care and services to the licensee's residents under the comprehensive license and began providing services under the assisted living with dementia care license on August 1, 2021. ULP-C's employee record indicated she had completed 6.25 hours of dementia training. ULP-E ULP-E was hired on December 8, 2021, to provide direct care services to residents of the facility.	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01540	Continued From page 39 ULP-E's employee record indicated she had completed 3 hours of dementia training. On March 15, 2022, at approximately 9:55 a.m., licensed assisted living director (LALD)-B confirmed the required amount of dementia training had not been completed for the above employees. LALD-B stated they try getting their staff to understand why required training needs to be done but they had been struggling with getting them to complete it. The licensee's undated Dementia Training policy indicated direct care staff would have a minimum of 8 hours of initial training on dementia care topics within 80 working hours and supervisors would have a minimum of 8 hours of initial training on dementia care topics within 120 working hours of the employment start date. The policy further indicated a minimum of 2 hours on training topcs related to dementia care topics would completed for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01770	Continued From page 40 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 14, 2022, at approximately 10:50 a.m., registered nurse (RN)-A confirmed the licensee provided medication management services to include medication setup. R3's diagnoses included Alzheimer's, chronic right shoulder and low back pain, anxiety, hypertension (high blood pressure), and osteoarthritis. R3's service plan dated September 27, 2021, indicated the resident received medication management services. R3's Assessment dated March 8, 2022, indicated the resident required medication management and medication setup services. R3's prescriber orders dated September 14, 2021, included an order for gabapentin 0.5	01770		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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01770	Continued From page 41 milliliters (ml) [equivalent to 25 milligrams/mg] (a medication to treat nerve pain) to be administered three times a day. On March 14, 2022, at approximately 2:00 p.m., unlicensed personnel (ULP)-C was observed to administer R3's scheduled gabapentin medication. ULP-C obtained a prefilled syringe of gabapentin 0.5 ml [equivalent to 25 mg] from the medication refrigerator. ULP-C stated the nurse setup R3's prefilled gabapentin syringes. R3's records lacked documentation for medication setup at the time of setup to include the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration, and name of person completing the medication setup. On March 14, 2022, at approximately 2:10 p.m., (RN)-A verified R3's medication setup for the resident's gabapentin was not documented in the resident's record to include the required content noted above. The licensee's Content of Client's Medication Record policy, undated, noted the client's record must contain the following information about the client's medications that the agency is managing to include documentation of any medication setup by the RN or licensed practical nurse (LPN). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01880 SS=F	144G.71 Subd. 19 Storage of medications	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 42 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 two of two medication refrigerators (memory care and assisted living) maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On March 14, 2022, at approximately 11:12 a.m., a tour of the facility was conducted with registered nurse (RN)-A, including a review of the "memory care" medication refrigerator. RN-A confirmed the current temperature was 48 degrees Fahrenheit (F). RN-A stated the medication refrigerator temperatures were monitored daily and recorded in their electronic record. RN-A stated she thought the acceptable temperature range was 32-48 degrees F. The refrigerator contained the following medications: - nineteen (19) pre setup 0.5 milliliter (ml)	01880		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLS CROSSING SENIOR LIVING	5307 HILLS CROSSING NISSWA, MN 56468

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01880	Continued From page 43 syringes of gabapentin (a medication to treat nerve pain) for R3; - one (1) bottle of gabapentin 250 milligrams (mg)/5 ml for R3; and - one (1) bottle of gabapentin 250 mg/5ml for R8. On March 14, 2022, at approximately 11:30 a.m., the "assisted living" medication refrigerator was reviewed with RN-A. RN-A confirmed the current temperature was 42 degrees F. The refrigerator contained the following medications: - fourteen (14) unopened Lantus 100 units/ml insulin pens (a multiple dose pen shaped injector device for insulin administration) for R4; - seven (7) unopened Novolog 100 units/ml insulin pens for R4; - eighteen (18) unopened Basaglar 100 units/ml insulin pens for R5; and - six (6) unopened bottles of latanoprost 0.005% (a glaucoma eye drop solution) for R6. The request was made to review the last 30 days of temperature logs for both medication refrigerators. On March 14, 2022, at approximately 11:40 a.m., the "memory care" and "assisted living" medication refrigerator temperature logs dated February 1, 2022, through March 13, 2022, were provided and reviewed with licensed assisted living director (LALD)-B. The "memory care" medication refrigerator temperature log had documentation daily (41 times); ten of the 41 times the actual temperature was not recorded (recorded as "done" or "no keys"). The "assisted living" medication refrigerator temperature log had documentation daily (41 times); twenty of the 41 times the actual temperature was not recorded (recorded as "done" or "no keys"). LALD-B confirmed the actual temperatures should be recorded daily and this was not consistently being	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 44 done to ensure the medication refrigerators maintained an acceptable temperature. The manufacturer's instructions for liquid gabapentin, dated October 2017, indicated the gabapentin should be stored in the refrigerator between 36 to 46 degrees F. The manufacturer's instructions for Lantus, dated May 2019, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. The manufacturer's instructions for Novolog, dated June 2021, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not freeze. The manufacturer's instructions for Basaglar insulin pens dated September 2021, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. The manufacturer's instructions for latanoprost eye drops dated, August 2011, indicated the unopened bottles should be stored in the refrigerator between 36 to 46 degrees F. The licensee's Central Storage of Medications policy, undated, noted medications kept in central storage must be kept in locked compartments under proper temperature controls. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 45	01890		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medication dates for two of two residents (R3, R7) and stock medications. 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 March 14, 2022, at approximately 11:12 a.m., a tour of the facility was conducted with registered nurse (RN)-A, including a review of the "memory care" medication cart. RN-A confirmed R3's open bottle of Deep Sea Nasal Spray (used to treat dryness inside the nasal passages) had expired January 2022. In the "memory care" medication room an open box of Bacitracin ointment 0.9 milligram (mg) (antibiotic ointment) packages had expired June 2021. RN-A stated the Bacitracin ointment was a stock medication.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 46 On March 14, 2022, at approximately 11:30 a.m., the "assisted living" medication cart was reviewed with RN-A. RN-A confirmed R7's open tube of Triamcinolone Acetonide 0.1% cream (corticosteroid) had expired August 2021. RN-A stated the night shift staff were supposed to be checking for expired medications. On March 14, 2022, at approximately 11:00 a.m., the licensee's assisted living with dementia care licensing policies and procedures were requested from registered nurse (RN)-A and LALD-B. The policies and procedures provided did not include a policy regarding expired medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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 one of one	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLS CROSSING SENIOR LIVING	5307 HILLS CROSSING NISSWA, MN 56468

(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
01960	Continued From page 47 resident's (R1) dressing change was provided as directed by the prescriber 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: R1's diagnoses included dementia, anemia, arthritis, and colostomy (an opening into the colon from the outside of the body which provides a new path for waste material to leave the body). On March 15, 2022, at approximately 8:04 a.m., unlicensed personnel (ULP)-C was observed to conduct a dressing change on R1's abdominal wound. Upon entering R1's room ULP-C performed hand hygiene and donned a pair of gloves. ULP-C gathered and prepared the dressing supplies from R1's bathroom. ULP-C and ULP-H transferred R1 from the wheelchair to her bed and positioned R1 on her back. ULP-C exposed R1's abdomen and with gloved hands removed the abdominal dressing which exposed an abdominal wound measuring approximately four centimeters (cm) by 0.5 cm. Using the same gloved hands, ULP-C moistened a 4x4 gauze dressing with water, placed the moistened dressing in the open abdominal wound, placed a cut ABD pad (a highly absorbent dressing that provides padding and protection for large wounds) over the moistened gauze dressing, which was packed into the abdominal wound, and	01960		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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01960	Continued From page 48 secured the ABD pad with tape. ULP-C gathered her supplies, removed her gloves, and performed hand hygiene. R1's prescriber orders dated June 24, 2021, included an order for daily wound care with specific instructions to remove the previous dressing (if any), wash gently with mild soap/water, pat dry; apply and pack lightly a wet kerlix to wound; cover with an ABD and tape. Notify the RN if any concerns. R1's Service Recap-Overall report dated February 14, 2022, through March 13, 2022, indicated R1 received a daily dressing change. On March 15, 2022, at approximately 8:35 a.m., ULP-C reviewed R1's dressing change instructions and confirmed she had missed the step of washing the wound with soap/water and patting the wound dry before packing the wound with a moistened gauze dressing. On March 15, 2022, at approximately 9:30 a.m., registered nurse (RN)-A stated it was her expectation for staff to follow the wound care instructions for R1's dressing change. The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders policy, undated, noted the provider would maintain a current treatment and therapy management record for each resident which would include verification that all treatment and therapy was administered as prescribed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 16, 2022, at approximately 11:30 a.m., the licensed assisted living director (LALD)-A provided documents for review. Documents were reviewed by survey staff on March 16, 2022, between 11:30 a.m. and 12:15 p.m. The Hazard Vulnerability Assessment did not include hazards	02040		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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02040	Continued From page 50 or safety risks identified on and around the property. On March 16, 2022, between 12:25 p.m. and 12:40 p.m., the LALD-A confirmed during the exit interview that the licensee failed to include safety risks or hazards identified on and around the property in the assessment. 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 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	02110		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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02110	Continued From page 51 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 develop and implement all required policies and procedures related to dementia care. 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: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. On March 14, 2022, at approximately 11:00 a.m., the licensee's assisted living with dementia care licensing policies and procedures were requested from registered nurse (RN)-A and licensed	02110		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

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02110	Continued From page 52 assisted living director (LALD)-B. The policies and procedures provided did not include the following: -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; -Medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; -Description of family support programs and 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; and -Safekeeping of residents' possessions. On March 15, 2022, at approximately 9:30 a.m., LALD-B confirmed the licensee had not developed the above required policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
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	02170		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02170	Continued From page 53 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have an evaluation for an activity plan for three of three residents (R1, R3, R4) who received services under an assisted living with dementia care license.	02170		

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02170	Continued From page 54 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: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. R1 R1's diagnoses included dementia, anemia, arthritis, and colostomy (an opening into the colon from the outside of the body which provides a new path for waste material to leave the body). R1's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions In addition, R1's record lacked the development of an individualized activity plan. R3 R3's diagnoses included Alzheimer's, chronic right shoulder and low back pain, anxiety,	02170		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02170	Continued From page 55 hypertension (high blood pressure), and osteoarthritis. R3's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - emotional and social needs and patterns; - physical abilities and limitations; and - adaptations necessary for the resident to participate In addition, R3's record lacked the development of an individualized activity plan. R4 R4's diagnoses included type two diabetes, compression fractures, and restless leg syndrome. R4's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions In addition, R4's record lacked the development of an individualized activity plan. On March 15, 2022, at approximately 9:20 a.m., licensed assisted living director (LALD)-B confirmed the licensee had not completed an activity evaluation or developed an activity plan for all current residents as required.	02170		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02170	Continued From page 56 The licensee's Activity Assessments policy, undated, noted the activity coordinator would meet with each new resident within seven days after moving to the facility to determine the resident's interests and abilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
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 and the frequency of training 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	02260		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLS CROSSING SENIOR LIVING	5307 HILLS CROSSING NISSWA, MN 56468

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02260	Continued From page 57 or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated Notice of Dementia Training policy did not include a description of the dementia care training program, the categories of employees trained and the frequency of training. On March 15, 2022, at approximately 9:30 a.m., LALD-B confirmed the licensee's disclosure did not contain all the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02260		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of three residents (R5) with bedrails and one of one residents (R1) with restraints. This resulted in an immediate correction order on March 15, 2022, at approximately 10:40 a.m.	02310		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLS CROSSING SENIOR LIVING	5307 HILLS CROSSING NISSWA, MN 56468

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02310	Continued From page 58 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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: BED RAILS On March 15, 2022, at approximately 8:25 a.m., the surveyor observed a bedrail on the left side near the head of the R5's bed. The bedrail was an open loop style which was held between the mattress and box spring, but did not secure to the bed frame or any other surface. R5 was observed to get out of bed with assistance from unlicensed personnel (ULP)-F. R5 did not utilize the bedrail to transfer out of bed but ULP-F stated the resident will periodically use the bedrail to get out of bed. R5's diagnoses included hemiparesis (weakness in one side of the body), type two diabetes, generalized weakness, and cerebral infarction (stroke) affecting left non-dominant side. R5's service plan, dated June 15, 2021, indicated the resident received the following services: assistance with bathing, grooming and hygiene, changing clothes, weekly laundry and housekeeping, daily snack, compression socks, and safety checks every 2 hours. R5's most recent assessment, dated January 26, 2022, indicated the resident had a partial 1/2 side rail on the left side of the bed. The assessment	02310		

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	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLS CROSSING SENIOR LIVING	5307 HILLS CROSSING NISSWA, MN 56468

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02310	Continued From page 59	02310		

indicated the opening of the side rail was 1 inch and was in compliance with FDA requirements. The assessment noted the indications for side rail use was for fall prevention, assistance in transfers to and from bed, and assistance with turning and repositioning. The assessment indicated the FDA brochure was reviewed with resident and his family and provider orders for a bed rail were obtained. The assessment noted zones of entrapment 1, 2, 3, and 4 were assessed and found to be in compliance with FDA requirements.

R5's prescriber orders, dated June 9, 2021, contained an order for 1/2 side rails but lacked further guidelines or recommendations.

On March 15, 2022, at approximately 9:50 a.m., registered nurse (RN)-A stated that family had brought R5's bed rail in and had installed it themselves when the resident admitted to the facility. RN-A stated she checked the bed rail and didn't note any issues at that time and obtained an order for the bed rail. RN-A stated if R5 pushed the rail hard, it would move and confirmed she had not assessed the bed rail for any recalls or reviewed the manufacturer's instructions. RN-A indicated she was not aware of how to measure the openings of the bedrails and stated that nobody had showed her the 4 zones of entrapment. RN-A stated if a resident was using a non FDA approved bed rail, her process would be to talk to family and get an FDA approved bed rail.

On March 15, 2022, at approximately 10:10 a.m., RN-A measured the bed rail with the surveyor present. The bed rail measured 12 inches tall by 11.5 inches wide, which was not in compliance with FDA guidelines for bed rails. Pressure was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLS CROSSING SENIOR LIVING	5307 HILLS CROSSING NISSWA, MN 56468

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02310	Continued From page 60	02310		

placed on the bed rail and it appeared loose and unsecure, which was confirmed by RN-A. RN-A confirmed the assessment did not contain accurate measurements and that a risk assessment had not been completed or reviewed with the resident or his representative.

R1 - BEDRAILS AND RESTRAINT
R1's diagnoses included dementia, anemia, arthritis and colostomy (an opening into the colon from the outside of the body which provides a new path for waste material to leave the body).

On March 15, 2022, at approximately 8:25 a.m., following a dressing change by unlicensed personnel (ULP)-C, R1 was observed laying in her bed on her back. R1's bed had bilateral full-length bedrails in the upright position. In addition, observed secured in the mattress overlay were four wedges, two on the upper and two on the lower portions of the mattress with a space between the upper and lower wedges measuring about 12 inches bilaterally. ULP-C stated the full-length bedrails were used to help prevent the resident from falling out of bed - for her "safety".

R1's service plan dated August 1, 2021, indicated R1 received services to include assistance with bathing, transferring, dressing, medication administration, and toileting.

R1's assessment dated January 18, 2022, indicated under the Mobility-Bed section that R1 had bilateral half rails on her bed. An order had been faxed and received from the provider for bilateral half bedrails. The RN had measured the openings in the bedrails and found them to be one (1) inch, within the recommended space to be less than 4 and ¾'s inches. The bedrail met

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLS CROSSING SENIOR LIVING	5307 HILLS CROSSING NISSWA, MN 56468

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02310	Continued From page 61 the requirements set by the FDA. The reason for the use of the bedrail was to help the resident with independence of safe mobility. R1's provider orders dated February 14, 2022, included an order for bilateral upper and lower bedrails for fall prevention and safety. On March 15, 2022, at approximately 9:42 a.m., registered nurse (RN)-A confirmed she had not included in her assessment the measurements of all the zones as required. RN-A was only measuring zone 3 (the measurement between the rail and the mattress). RN-A stated she was unaware that an overlay with wedges had been placed on R1's mattress. RN-A verified that the full-length bedrails and mattress with wedges would be considered a restraint. RN-A confirmed the licensee did not have a process for assessing for a restraint or a procedure of what to do if a restraint was identified. On March 15, 2022, at approximately 10:03 a.m., R1's full-length bedrails were measured with RN-A. RN-A verified the opening of zone 1 measured four (4) inches vertically and six (6) inches horizontally. The bedrail zone measurements met the FDA requirements. RN-A confirmed again R1's bilateral full-length bedrails and mattress with wedges would make it difficult for the resident to get out of bed. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27831	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLS CROSSING SENIOR LIVING	5307 HILLS CROSSING NISSWA, MN 56468

(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
02310	Continued From page 62 bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The licensee's undated Assessing the Safety of Side Rails policy indicated the RN will evaluate whether or not the side rail is safe for the resident. The policy directed if a side rail did not meet FDA standards, the side rail would be removed and the RN would document the recommendation. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The immediacy of the order was removed at 4:00 p.m. on March 15, 2022. This was confirmed by the surveyor's on-site observation and approved by evaluation supervisor. No further action required.	02310		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *03/14/22*
Time: 13:00:00
Report: 1017221042

Food and Beverage Establishment Inspection Report

Location:
Hills Crossing Senior Living
5307 Hills Crossing
Nisswa, MN56468
Crow Wing County, 18

Establishment Info:
ID #: 0025548
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Welcome Home Health Care, Inc.

Phone #: 2189615605
ID #: 44045

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C3 ** Priority 1 **

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

QUAT MEASURED 100 PPM LOCATED IN BOTH WIPING CLOTH BUCKETS, MAINTAIN AT 200 PPM. BUCKETS WERE FILLED WITH NEW SOLUTION AND MEASURED 200 PPM.

Corrected on Site

2-100 Supervision

2-102.11DEFG ** Priority 2 **

MN Rule 4626.0030DEFGHI The person in charge must be able to demonstrate their knowledge to the inspector of the importance of the following food handling procedures to preventing foodborne disease: handwashing; avoiding cross contamination; avoiding hand contact with ready-to-eat foods; time and temperature requirements for safely refrigerating, hot holding, cooling, and reheating TCS food; hazards of eating raw or undercooked meat, poultry, eggs, and fish; food temperatures and cooking times required to safely cook TCS food including meat, poultry, eggs, and fish; foods identified as major food allergens and the symptoms of an allergic reaction; identification of critical control points in a food service operation and steps to be taken to ensure the points are controlled.

CINDY STATED THAT SHE WAS COOKING MEAT LOAF TO 125 DEGREES. COOKING TEMPS WERE DISCUSSED AND FOOD TEMP GUIDE WAS SENT WITH REPORT.

Comply By: 03/14/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

PROVIDE THERMO LABELS OR MIN MAX LOLLIPOP THERMOMETER TO MEASURE DISH MACHINE.

Comply By: 04/04/22

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

PROVIDE QUAT TEST STRIPS.

Comply By: 03/28/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

PROVIDE POSTER IN EMPLOYEE USED BATHROOM LOCATED BY DINING ROOM.

Comply By: 03/21/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

CAULKING NEXT TO SPRAY SINK AND WALL HAS BLACK MOLD, CLEAN TO BE FREE OF MOLD.

Comply By: 03/21/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 100 at Degrees Fahrenheit
Location: QUAT WIPING CLOTH BUCKET
Violation Issued: Yes

Quaternary Ammonia: = 100 at Degrees Fahrenheit
Location: QUAT WIPING CLOTH BUCKET DINING ROOM
Violation Issued: Yes

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: QUAT WIPING CLOTH BUCKET REFILL
Violation Issued: No

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: QUAT WIPING CLOTH BUCKET REFILL
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *03/14/22*
Time: 13:00:00
Report: 1017221042
Hills Crossing Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: JAMBOLAYA LOCATED IN TWO DOOR UPRIGHT
Violation Issued: No

Process/Item: Hot Holding
Temperature: 167 Degrees Fahrenheit - Location: POTATOES LOCATED ON STOVE TOP
Violation Issued: No

Process/Item: Cooking
Temperature: 175 Degrees Fahrenheit - Location: MEAT LOAF LOCATED IN OVEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: PEACHES LOCATED IN UNDER COUNTER COOLER

Violation Issued: No

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

DISCUSSION:

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1017221042 of 03/14/22.

Certified Food Protection Manager: CINDY M. LIZOWSKI

Certification Number: FM 61343 Expires: 02/16/24

Inspection report reviewed with person in charge and emailed.

Signed: _____ Establishment Representative

Signed: _____ INSPECTOR ID # 1017

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