



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 19, 2023

Licensee

Suite Living Senior Care of Spring Lake Park LLC
525 Osborne Road
Spring Lake Park, MN 55432

RE: Project Number(s) SL39404015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license with dementia care**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on September 15, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state 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. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

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

The total amount you are assessed is \$500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. §

626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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 the letter and/or state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/15/2023
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF SPRING LAKI			STREET ADDRESS, CITY, STATE, ZIP CODE 525 OSBORNE ROAD SPRING LAKE PARK, MN 55432		
(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 *****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: SL39404015 On September 11, 2023, through September 14, 2023, 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 active residents whom were receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 (13) offer to provide or make available at least the	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 following services to residents: (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 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 September 12, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in	0 510			

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0 510	Continued From page 2 assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for one of one unlicensed personnel ((ULP)-B) observed to provide personal cares and medication administration for multiple residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observation and interview on September 12, 2023, starting at 7:56 a.m., ULP-B was at the central memory care unit medication cart training ULP-F for the shift on medication administration and cares. ULP-B set up R8's morning medications, donned (put on) gloves, entered R8's room, and administered medications. ULP-B doffed (removed) gloves within the apartment, left to document administration at the medication cart without hand hygiene (HH) before leaving room. After documentation, ULP-B washed hands. ULP-B returned to R8's apartment, donned gloves and performed perineum care after a	0 510			

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0 510	Continued From page 3 bowel movement. Without removing soiled gloves, ULP-B grabbed a tube Calmoseptine cream (skin protectant), applied to R8's bottom, put the cream back onto R8's bed, and continued to place a clean brief, touched clothing, and placed the cream into her/his shirt pocket. ULP-B then proceeded to fix R8's pillow and placed blanket on R8 before doffing gloves. Without HH, ULP-B donned clean gloves, changed R8's shirt and washed his face and underarms. ULP-B doffed gloves to set up and administer R8's oxygen. ULP-B exited room, without HH, went into R5's room to speak with his family. ULP-B then went to medication cart, pulled out the Calmoseptine cream which was handled with soiled gloves earlier, placed it back into the medication cart and began logging into the computer to set up R5's medications. ULP-B pulled out a clean syringe and was about to punch out a medication from the bubble pack when surveyor intercepted and asked ULP-B to wash hands. ULP-B stated, "I need to do that." ULP-B discarded the syringe and retrieved a new one to set up medications. ULP-B entered R5's apartment, donned gloves, administered medications then performed perineum care, changed brief, repositioned R5 in bed, grabbed the bed remote to adjust the bed, removed trash then doffed gloves and washed hands. Surveyor did not observe HH or glove change right after performing medication administration or personal cares. During observation and interview on September 12, 2023, at 9:52 a.m., ULP-B entered R4's apartment to obtain vital signs (temperature, pulse, and oxygen saturation by applying oximeter to finger). ULP-B put the vital sign equipment back into his/her uniform pocket. Surveyor asked when the shared equipment was	0 510			

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0 510	Continued From page 4 cleaned. ULP-B stated the overnight staff wipe them down and ULP-B would wipe it down at the end of his/her shift. ULP-B stated, "to be honest, I don't wipe it in between, but I should be wiping it after every care." ULP-B stated he/she received infection control training at orientation. ULP-B training record dated April 12, 2023, included demonstrated competencies on handwashing, hand sanitizer, personal cares, and surface disinfecting. During interview on September 12, 2023, at 3:30 p.m., clinical nurse supervisor (CNS)-A stated all infection control training is covered in the classroom training. CNS-A expected gloves doffed before leaving resident rooms, when finished changing a brief and before the next task. Hand hygiene between medication pass, use the concept of "foam in and foam out," when entering and exiting resident rooms. The licensee's 8.03 Cleaning of Shared Medical Equipment policy dated July 20, 2021, indicated in accordance with existing infection prevention and control policies and procedures, the licensee would implement and maintain processes to ensure all reusable resident care equipment is routinely cleaned, and when appropriate, disinfected, before and after reuse. The licensee's 8.07 Gloves policy dated July 20, 2021, indicated hands must be washed after removing gloves. The licensee's 8.09 Hand washing policy dated July 20, 2021, indicated proper hand washing techniques should be used between tasks and after bathroom use to prevent cross contamination.	0 510		

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0 510	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	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 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	0 810		

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0 810	Continued From page 6 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on September 12, 2023, at approximately 1:30 p.m. with Regional Director of Operations (RDO)-E, on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for resident movement, evacuation, or relocation during a fire	0 810			

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0 810	Continued From page 7 or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. During interview, RDO-E, verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01690 SS=D	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about	01690			

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01690	Continued From page 8 medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow current medication management policies and procedures on medication re-ordering for one of five residents (R13) receiving medication services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 September 11, 2023, at approximately 10:15 a.m., clinical nurse supervisor (CNS)-A confirmed the licensee provided medication management services to the licensee's residents. R13 admitted to licensee on June 13, 2023, with diagnoses of long-term use of anticoagulants (blood thinner), acute embolism and thrombosis of left femoral vein (obstruction of blood flow to large blood vessel in upper thigh), and venous insufficiency (blood pools in veins).	01690			

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01690	Continued From page 9 R13's Service Agreement signed on June 13, 2023, indicated R13 received medication management assistance and licensee's nurse was to process new orders and order medications as needed. R13's medication administration record (MAR) dated August 2023, and September 2023, indicated R13 received Jantoven (anticoagulant) tablet 5 milligrams (mg) by mouth in the evening with a discontinuation date of September 11, 2023. On the following dates, under Jantoven 5 mg, it was documented with a code "11" which meant "medication not available:" -August 31, 2023; and -September 1, 2, 4, 5, and 6, 2023. R13's Progress Notes dated August 25, 2023, at 3:20 p.m., indicated by a registered nurse (RN) they "received a call from INR [blood test to determine how long it takes blood to clot] Lab stating that Jantoven dose will remain 5 mg until the results of the next draw." R13's Progress Notes dated September 11, 2023, at 4:23 p.m., indicated an order for Jantoven 10 mg for one day. R13's Progress Notes dated September 12, 2023, at 4:29 p.m., indicated an order for Jantoven 10 mg for two days. R13's Progress Notes dated September 12, 2023, at 4:31 p.m., indicated an order for Jantoven 10 mg for tonight then 5 mg all other days. INR to do lab draw on September 18, 2023.	01690			

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01690	Continued From page 10 R13's Progress Notes dated September 13, 2023, at 3:14 p.m., indicated an order for aspirin 81 mg to cover not being able to get Lovenox (injections to thin blood). During interview on September 12, 2023, at 3:30 p.m., clinical nurse supervisor (CNS)-A stated unlicensed personnel would tear off the top of a bubble pack when the medication ran out and placed it into a bin in the nursing office which indicated a refill was needed. CNS-A also stated there are pharmacy sheets available at the medication cart for the ULP to write down the medication that needs to be refilled. During interview on September 14, 2023, at 1:18 p.m., CNS-A stated R13 had his factor 10 (tests protein in blood that helps blood clot) lab drawn on Fridays and it took a few hours to process, and results would return to licensee on Saturdays. The clinic was closed on weekends so RN could not obtain the new Jantoven orders until Monday. CNS-A stated there was a lab draw scheduled on the "1st or 2nd of September," but she (the nurse) did not return from her vacation until Tuesday, September 5, 2023. CNS-A stated the clinic requested the licensee to administer Lovenox injection every 12 hours, but ULP are unable to perform injections, they ordered aspirin 81 mg for seven days instead. The licensee's 7.19 Medication & Supplies-reordering policy dated July 20, 2021, indicated nursing staff would assist residents to make sure medications and supplies were ordered and available as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2)	01690			

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NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF SPRING LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 525 OSBORNE ROAD SPRING LAKE PARK, MN 55432		
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01690	Continued From page 11	01690			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be	01730			

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01730	Continued From page 12 current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for one of three residents (R3). 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: On September 12, 2023, at 10:43 a.m., during interview with R3, unlicensed personnel (ULP)-G entered apartment, removed left Farrow wrap (reduces swelling) and compression sock from R3's lower left leg and applied Clobetasol cream (for skin irritation) to ankle. ULP-G replaced compression sock and Farrow wrap and proceeded to do the same for R3's right lower leg. R3's Assessment of Need for Medication Reminders, Assistance, Administration or Central Storage dated June 7, 2023, indicated R3 required assistance with medication management	01730			

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01730	Continued From page 13 due to cognitive impairment/forgetfulness. R3's Service Agreement signed on June 7, 2023, indicated R3 received medication administration assistance. R3's provider orders dated July 18, 2023, ordered nystatin powder 100000 unit/gram-apply to affected areas topically two times a day for skin. R3's provider orders dated September 6, 2023, ordered Clobetasol 0.05% ointment-apply thin layer to [affected] area on ankle twice daily for two weeks. Ok to repeat two weeks on, two weeks off. R3's medication administration record (MAR) dated September 2023, indicated the following: -Clobetasol 0.05%-apply to affected area on ankle topically two times a day for dermatitis for two weeks; and -nystatin external powder 100000 unit/gram-apply to affected areas topically two times a day for skin. R3's medical record lacked the following for each medication: - documentation of specific resident instructions relating to the administration of medications (amount, and specific location to apply). During interview on September 14, 2023, at 11:55 a.m., ULP-F stated the area was unknown for nystatin powder application and the MAR should specify where to apply. ULP-F also stated for Clobetasol ointment, he/she would locate a rash or redness, but the MAR should indicate which or both ankles for application. During interview on September 14, 2023, at 1:18	01730			

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01730	Continued From page 14 p.m., clinical nurse supervisor (CNS)-A stated the instructions for medication administration of creams were not clear by indicating where to apply them. CNS-A stated orders received by the provider were sometimes vague. The licensee's 7.15 Medication & Treatment-Administration & Delegation policy dated July 2021, indicated the RN would specify, in writing, specific instructions for each resident and documented those instructions in each resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01760			

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01760	Continued From page 15 review, the licensee failed to ensure medications were administered as prescribed for two of six residents (R8, R5) receiving medication management. Additionally, the licensee failed to transcribe standing orders for one of three residents (R4) receiving medication management. 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: MEDICATION ERROR R8 During observation on September 12, 2023, at 7:56 a.m., unlicensed personnel (ULP)-B was setting up R8's morning medications. ULP-B pulled one tablet of quetiapine fumarate (antipsychotic) 25 milligram (mg) and placed it into the medication cup with the rest of the medications. Just before ULP-B began to crush the tablets, surveyor stopped her/him and asked to recheck the medication administration record (MAR) for the quetiapine dose. The MAR indicated to administer half of a tablet (12.5 mg) twice a day. ULP-B realized the mistake and informed clinical nurse supervisor (CNS)-A and CNS-A used a pill cutter to cut the tablet in half and placed the other half tablet back into the bottle. ULP-B then completed the medication administration.	01760			

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01760	Continued From page 16 R8 was re-admitted to licensee from the hospital on September 11, 2023, with diagnoses of Alzheimer's Disease, congestive heart failure, and pneumonia. R8's Individual Resident Care Plan last revised on September 11, 2023, indicated R8 required assistance with medication administration. R8's RN assessment dated September 11, 2023, indicated R8 was unable to manage his own medications and required assistance. R5 During observation on September 12, 2023, at 9:10 a.m., ULP-B began setting up morning medications for R5. While ULP-B set up two (2) solu-tabs (dissolvable under tongue) of morphine which required ULP-B to locate page 11 in the narcotic logbook to document the resident, medication, dose, date, time and amount remaining in the bubble pack after removal. ULP-B documented five tabs remaining. Surveyor observed it was documented by ULP-I on September 11, 2023, at 4:09 p.m., and 7:34 p.m., one tab of morphine 2.5 mg was removed for administration, when two tabs were ordered. On September 11, 2023, at 11:15 p.m., ULP-J documented one tab of morphine was removed for administration, when two tabs were ordered. R5's MAR dated September 1, 2023, through September 12, 2023, indicated scheduled morphine 2.5 mg solu-tab (two tabs) began on September 11, 2023, at 4:00 p.m. During interview on September 12, 2023, at 3:30 p.m., CNS-A stated narcotic audits were usually performed once a week by going through the	01760			

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01760	Continued From page 17 narcotic drawer, highlighting any pages that are completed (bubble pack ran out), looking to make sure narcotics were administered correctly, and during mid-week would check supplies for reordering. During interview on September 13, 2023, at 9:01 a.m., ULP-J stated R5's MAR indicated two tablets, but the bubble pack label indicated one tab. ULP-J stated it would be helpful if the bubble pack label was corrected to match the MAR. ULP-J stated she/he didn't want to bother the nurse for things like that when unsure. On September 13, 2023, at 10:26 a.m., CNS-A provided surveyor with written employee counseling for ULP-B and ULP-I and stated ULP-B would be going through medication training course again. Surveyor explained to CNS-A that ULP- J also documented one tab, not two. CNS-A stated only one tab was given and that would be addressed also. TRANSCRIPTION ERROR R4 R4's Service Agreement signed on August 16, 2023, indicated R4 received medication management services. R4's 90-day RN assessment dated August 4, 2023, indicated R4 was unable to manage own medications and required assistance. R4's Routine Standing Orders signed on June 23, 2023, ordered the following medications as needed: acetaminophen (pain), aspirin (chest pain), loperamide (diarrhea), regular strength antacid (heartburn), milk of magnesia and bisacodyl suppository (constipation), guaifenesin and menthol cough drops (cough), Claritin	01760		

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01760	Continued From page 18 (allergies), hydrocortisone cream and nystatin powder (rash), and triple antibiotic ointment (topical antibiotic). R4's Medication Administration Record (MAR) dated September 1, 2023, through September 12, 2023, did not include the above medications. On September 14, 2023, at 1:18 p.m., CNS-A stated all standing orders were renewed June 23, 2023. CNS-A could not explain why the standing orders were not transcribed onto R4's MAR and she would complete that. The licensee's 7.15 Medication & Treatment-Administration & Delegation policy dated July 2021, indicated the RN would: -instruct the ULP in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP would demonstrate the ability to competently follow the procedures. Additionally, the ULP must demonstrate their ability to competently follow the delegated medication administration or treatment/therapy to an RN. The licensee's 7.26 Narcotic Log policy dated July 20, 2021, indicated the RN supervisor would verify the documentation in the Narcotic Logbook including counts and records regularly. The licensee's 7.22 Medication & Treatment Record-Documentation & Refusal policy dated July 20, 2021, indicated the licensee would create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving medication assistance or administration and/or treatments and therapies.	01760			

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01760	Continued From page 19 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01890 SS=D	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 ensure medications included labeling with an opened-on date for two of three residents (R7, R11) receiving medication management. 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: On September 12, 2023, at approximately 11:50 a.m., surveyor observed unlicensed personnel (ULP)-G set up medications and insulin for R12. Within the medication cart, surveyor observed the following insulin pens without an open-on date:	01890			

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01890	Continued From page 20 -R7's NovoLog (insulin aspart) 100unit (u)/milliliter (ml) with approximately 120 units remaining; and -R11's NovoLog (insulin aspart) 100 units/ml which appeared to be brand new. R7 R7's Service Agreement signed on March 17, 2023, indicated R7 received medication management including assistance with blood glucose checks and insulin administration. R7 had a diagnosis of type two diabetes mellitus. R7's medication administration record (MAR) dated September 2023, indicated R7 took NovoLog FlexPen insulin (insulin aspart 100 units/ml pen); administer three (3) times per day with meals for the following blood glucose (BG) results: - if 151-199=1u; - 200-249=2u; - 250-299=3u; - 300-349=4u; and - 350-600=5u. R11 R11's Service Agreement signed on August 16, 2023, indicated R11 received medication management including assistance with insulin administration. R11 had type two diabetes mellitus. R11's medication administration record (MAR) dated September 2023, indicated R11 took NovoLog FlexPen insulin (insulin aspart 100 units/ml pen); administer three times per day before meals for the following blood glucose (BG) results: - if 0-149=0; - 150-199=1u; - 200-249=2u;	01890			

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01890	Continued From page 21 - 250-299=3u; - 300-349=4u; - 350-399=5u; and - 400-999=6u. On September 12, 2023, at 11:56 a.m., regional registered nurse (RN)-C stated insulin should always be labeled with an opened-on date. Manufacturer's instructions for Novolog Flexpen last revised on February 2023, indicated the pen should be discarded after 28 days. The licensee's 7.11 Medication Storage policy dated July 2021, indicated medications would be kept securely locked and stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy management For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions	01940			

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01940	Continued From page 22 relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management plan to include all required content for three of three residents (R2, R3, R4) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2 R2's Service Agreement signed on December 28,	01940			

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01940	Continued From page 23 2022, indicated R2 was independent with blood glucose checks, but did not indicate if R2 or licensee was responsible for the application of Jobst stockings (compression stockings). R2's 90-day registered nurse (RN) assessment dated September 12, 2023, stated staff would not perform blood sugar checks, but R2 required assist of one unlicensed personnel (ULP) for compression stockings. R2's prescriber orders dated January 26, 2023, ordered Jobst stockings knee high, place on in morning (AM) and remove at bedtime (HS). R2's medication administration record (MAR) dated September 2023, indicated R2 checked his own blood sugar, but ULPs recorded the results of the blood sugar. The MAR indicated daily documentation for application and removal of Jobst stockings. R2's individual treatment management plan lacked the following content: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; and - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. On September 11, 2023, at 2:26 p.m., R2 stated he used to check his own blood glucose, but when he ran out of needles, the licensee started checking his blood glucose daily. On September 12, 2023, at 1:00 p.m., surveyor	01940			

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NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF SPRING LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 525 OSBORNE ROAD SPRING LAKE PARK, MN 55432			
(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
01940	Continued From page 24 did not observe compression stockings on R2. R2 stated his medical provider prescribed them when he was fainting but had not worn them for the last three months. He stated he chose not to wear them, and staff were informed. During interview on September 12, 2023, at 1:05 p.m., ULP-G and ULP-H stated R2 never wore his compression stockings, ULP-G stated, "I don't think he has worn them since he moved in." Surveyor asked if anyone notified the RN, and ULP-G stated they weren't sure if anyone did. During interview on September 12, 2023, at 3:30 p.m., clinical nurse supervisor (CNS)-A stated R2 checked his own blood glucose and reported the results to the ULP. CNS-A stated she requested an order to discontinue the compression stockings but did not hear back from the provider yet. During interview on September 13, 2023, at 11:00 a.m., ULP-B and ULP-G stated R2 had his blood glucose checked daily by licensee for a long time. The licensee used R2's blood glucose device and kept it in the central medication cart. During interview on September 13, 2023, at 3:43 p.m., surveyor informed CNS-A that R2 had not been doing his own blood glucose checks. CNS-A stated she was informed by R2 that he needed more strips to perform the blood glucose checks, but she did not know staff had been performing the task lately. R3 R3's Service Agreement signed on June 7, 2023, indicated R3 received assistance with "Ace Wraps, TED hose, Surgical Stockings," and to refer to MAR for frequency and schedule.	01940			

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01940	Continued From page 25 R3's 90-day RN assessment dated September 7, 2023, stated R3 had edema (swelling) and indicated R3 wore compression stockings. R3's prescriber orders dated July 18, 2023, ordered both compression stockings and Farrow wraps two times a day (on in AM and off at night for edema). R3's MAR dated September 2023, indicated ULPs were documenting they applied compression stockings in the morning and removed at night daily. Additionally, the ULPs were documenting they applied Farrow wraps to both lower legs in the morning and removed at night daily. R3's individual treatment management plan lacked the following content: - documentation of specific resident instructions relating to the treatments or therapy administration; and - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. During observation and interview on September 12, 2023, at 10:30 a.m., surveyor observed ULP-G remove both Farrow wraps and compression stockings to apply an ointment to both ankles. Once completed, ULP-G replaced both Farrow wraps and compression stockings to R3's lower legs. R3 stated she had observed ULPs do it differently but was able to instruct on how to apply them. R3 stated she did not have Farrow wrap instructions available for staff to reference.	01940			

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01940	Continued From page 26 R4 R4's Service Agreement signed on August 16, 2023, indicated R4 received assistance with continuous oxygen therapy. R4's 90-day assessment dated August 4, 2023, assessed R4 required assistance with oxygen therapy. R4's medical record lacked the following: - documentation of specific resident instructions relating to the treatments or therapy administration; and - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. During interview on September 14, 2023, at 1:18 p.m., CNS-A was unaware R4's record lack documentation for oxygen administration. CNS-A recalled adding it to the MAR at admission but could not explain why it was missing. The licensee's 7.05 Treatment & Therapy Management Plan policy dated July 2021, indicated it would include the missing content listed above in the resident's current individualized treatment and therapy management plan.	01940			

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01940	Continued From page 27 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating the nursing tasks or treatments, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident and were able to demonstrate the ability to competently follow the procedure to a registered nurse (RN) for one of one unlicensed personnel ((ULP)-B).	01950			

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01950	Continued From page 28 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: ULP-B started employment with the licensee on April 4, 2023. ULP-B's employee record indicated they had received training for ACE wraps and compression stockings. During observation and interview on September 12, 2023, at 10:30 a.m., surveyor observed ULP-G remove both Farrow wraps and compression stockings to apply an ointment to both ankles. Once completed, ULP-G replaced both Farrow wraps and compression stockings to R3's lower legs. R3 stated she has observed ULPs do it differently but was able to instruct on how to apply them. R3 stated she did not have Farrow wrap instructions available for staff to reference. During interview on September 12, 2023, at 9:10 a.m., ULP-B stated they received training with corporate trainer (RN)-K in a classroom setting for two days and did demonstrations on each other for mechanical lifts, repositioning, dressing wounds, catheter care, medication administration, wraps/compression stockings, slings, oxygen, and etcetera.	01950			

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01950	Continued From page 29 During interview on September 12, 2023, at 10:43 a.m., ULP-G didn't recall getting trained on lymphedema wraps (Farrow wraps). ULP-G stated they may have done it at orientation training. During interview on September 12, 2023, at 10:10 a.m., RN-K stated during orientation training, the figure "8" and spiral with ACE wraps are demonstrated along with compression stockings. RN-K stated Farrow wraps, or any other types of wraps were not available to demonstrate so staff would need to be trained on site by the RN. During interview on September 13, 2023, at 3:02 p.m., clinical nurse supervisor (CNS)-A stated RN-K started the training program April 2023. CNS-A stated R3 was very hands on and explained to the ULP how to apply it. CNS-A stated the ULPs were not trained when to notify a nurse if there were issues with the wrap itself or when applying the wrap. CNS-A stated all staff would be trained on Farrow wraps next Friday. The licensee's 7.15 Medication & Treatment-Administration & Delegation policy dated July 2021, indicated the RN would: -instruct the ULP in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP would demonstrate the ability to competently follow the procedures; and -specified, in writing, specific instructions for each resident and documented those instructions in the residents' records; and -communicated with the ULP about the individual needs of the resident. No further information was provided.	01950		

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01950	Continued From page 30	01950		
	TIME PERIOD FOR CORRECTION: Seven (7) days			
01960 SS=F	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 document treatment administration for two of three residents (R2, R4). Additionally, the licensee failed to ensure oxygen was available as ordered for one of two residents (R8) for an unknown period of time. 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:	01960		

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01960	Continued From page 31 DOCUMENTATION ERROR R2 R2's Service Agreement signed on December 28, 2022, did not indicate whether compression stockings were going to be applied by R2 or by licensee. R2's 90-day registered nurse (RN) assessment dated September 12, 2023, assessed R2 required assist of one unlicensed personnel (ULP) for compression stockings. R2's prescriber orders dated January 26, 2023, ordered Jobst stockings knee high, place on in morning (AM) and remove at bedtime (HS). On September 12, 2023, at 1:00 p.m., surveyor did not observe compression stockings on R2. R2 stated his medical provider prescribed them when he was fainting but had not worn them for the last three months. He stated he chose not to wear them, and staff were informed. R2's medication administration record (MAR) dated September 1, 2023, through September 11, 2023, indicated daily documentation (a check mark above the initials) for application at 7:00 a.m., and removal of Jobst stockings at 8:00 p.m. R2's medical record lacked the following documentation for compression stocking administration: -when treatment was not administered as ordered or prescribed, the licensee must document the reason why it was not administered and any follow up procedures that were provided to meet the resident's needs. During interview on September 12, 2023, at 1:05	01960			

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01960	Continued From page 32 p.m., ULP-G and ULP-H stated R2 never wore his compression stockings, ULP-G stated, "I don't think he has worn them since he moved in." Surveyor asked if anyone notified the RN, and ULP-G stated they weren't sure if anyone did. During interview on September 12, 2023, at 1:50 p.m., surveyor showed ULP-G and ULP-H the MAR which had documentation of check mark above initials daily, and they stated that meant the compression stockings were applied and removed. ULP-H stated she would ask R2 if he wanted his compression stockings and ULP-G stated as a medication passer, she relied on staff who perform R2's morning cares to apply the compression stockings, and she would document they were applied. ULP-G stated she was guilty of charting for something that wasn't done. During interview on September 12, 2023, at 3:30 p.m., clinical nurse supervisor (CNS)-A stated she requested an order to discontinue the compression stockings a while ago, but the provider didn't get back to her. CNS-A stated it was procedure for staff to document refused on the MAR if R2 declined a treatment, and staff have the option to put an explanation in the progress notes. If a check mark above the initials were present, that meant the treatment was completed. A number "2" above the initials meant R2 refused the treatment. During interview on September 13, 2023, at 3:43 p.m., CNS-A stated she received an order today to discontinue compression stockings and would update R2's medical record. R4 R4's Service Agreement signed on August 16, 2023, indicated R4 received assistance with	01960			

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01960	Continued From page 33 oxygen therapy. R4's service documentation dated September 1, 2023, through September 14, 2023, lacked documentation on providing oxygen therapy service. R4's MAR dated September 1, 2023, through September 12, 2023, lacked documentation of oxygen therapy administration. On September 12, 2023, at 9:41 a.m., surveyor observed ULP-B and ULP-F enter R4's room to administer morning medications. R4 was sleeping in his hospital bed with a nasal cannula tube (delivers oxygen into the nose) inserted into his nares. Surveyor observed the oxygen concentrator (reduces nitrogen from ambient air) setting at 4 liters of oxygen per minute. R4's medical record lacked the following documentation for oxygen administration: -who provided the treatment; -date and time when the treatment was provided; and -when treatment was not administered as ordered or prescribed, the licensee must document the reason why it was not administered and any follow up procedures that were provided to meet the resident's needs. During interview on September 14, 2023, at 1:18 p.m., clinical nurse supervisor (CNS)-A stated she was unaware oxygen therapy was not being documented by ULP's. She stated she recalled adding it on the MAR when R4 moved in, but unsure why it was not on there now. ADMINISTRATION ERROR R8	01960			

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01960	Continued From page 34 R8 was re-admitted to licensee from the hospital on September 11, 2023. R8's Individual Resident Care Plan last revised on September 11, 2023, indicated R8 required assistance with scheduled oxygen therapy. R8's MAR dated September 11-12, 2023, indicated R8 required 1-2 liters (L) of oxygen per min via nasal cannula continuous on every shift for congestive heart failure and pneumonia. During observation and interview on September 12, 2023, starting at 7:56 a.m., ULP-B set up R8's morning medications at the central medication cart in the common area of the memory care unit. Upon R8's apartment located at the other side of the unit, found R8 lying in bed without a nasal cannula on and concentrator was off. Surveyor was informed power was off in R8's room and had been off for a period of time. Surveyor observed three different sized portable oxygen cylinders located in the main area of the apartment in plain sight (two near resident's bed and one near the entry door.) ULP-B administered R8's medication while he was in bed, then left apartment to document medication administration at the medication cart. Surveyor asked ULP-B if they were trained how to use the portable oxygen cylinders, and ULP-B responded that he/she knew how to use the portable cylinders. Before starting morning cares, surveyor asked ULP-B to switch the nasal cannula to the portable oxygen cylinder, and ULP-B stated they will do that after the cares. ULP-B then proceeded to complete morning cares (dressing, catheter care, toileting, brief change, and face wash). At 8:50 a.m., surveyor instructed ULP-B for the second time to apply oxygen to R8. While ULP-B was trying to figure out how to set up the	01960			

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01960	Continued From page 35 portable cylinder, ULP-B stated he/she wasn't trained on oxygen, but just knew how to put the tubing on. Once Surveyor assisted ULP-B set up the portable cylinder, surveyor asked what the oxygen setting should be, ULP-B stated "3 will be good," then applied the nasal cannula to R8's nostrils. At 8:55 a.m., the electricity turned on. ULP-B switched the oxygen from the portable cylinder to the concentrator and put the setting between 1.5 and 2 L. During that period of time, surveyor did not observe R8 to be in any respiratory distress as R8 was able to have conversations and laughed with staff. During interview on September 12, 2023, at 3:30 p.m., CNS-A stated she had not been in orientation class but has seen competency packets received from orientation regarding oxygen training. CNS-A stated residents receiving oxygen have a concentrator with portable oxygen cylinders. Surveyor asked what the process was for checking correct oxygen administration. CNS-A stated "I guess I don't have one," all staff were trained on the concentrator. If staff could not figure out the portable cylinders, they should use the concentrator as a default, even if in common areas, and would provide training the next day. During interview on September 13, 2023, at 9:01 a.m., ULP-J stated he/she worked the night before in the memory care unit and ULP-M and ULP-N worked in the assisted living unit. ULP-J stated the power kept going on and off, which started around midnight or 1:00 a.m. ULP-J heard a beep sound coming from R8's apartment when the power went out. Since this was a power outage, ULP-J contacted regional director of operations (RDO)-E and was informed the problem would be fixed in the morning when maintenance arrived. ULP-J did not contact the	01960			

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01960	Continued From page 36 nurse on-call for instruction nor did ULP-J switch R8 to the portable oxygen cylinders. ULP-J could not recall if the portable oxygen cylinders were present in the room. During interview on September 13, 10:10 a.m., corporate trainer (RN)-K explained staff were trained and demonstrated competency on how to use portable oxygen cylinders but could not do a demonstration on concentrators due to availability. RN-K stated staff watched a training video on how to use a concentrator and the onsite RN would complete the competency evaluation with staff. During interview on September 13, 2023, at 10:26 a.m., CNS-A stated the portable oxygen cylinders were delivered on Monday, September 11, 2023, when R8 returned from the hospital. During interview on September 14, 2023, at 1:18 p.m., RN-K further explained the concentrator training video did not tell staff what to do if the power goes out. RN-K stated she will incorporate that in her teaching. During interview on September 14, 2023, at 2:45 p.m., RDO-E was notified at 8 p.m. on [Sunday] that the power was out. RDO-E instructed staff to reset the breaker and it went back on. At 2:00 a.m., RDO-E was notified the power was out again and instructed staff to unplug all non-essential outlets except for the power bed and concentrator. RDO-E was then informed power was working. RDO-E did not receive any further calls that night by overnight staff. ULP-B's employee record dated April 13, 2023, included competencies on oxygen concentrators and portable oxygen cylinders.	01960			

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01960	Continued From page 37 ULP-B's Notes on Supervision of Unlicensed Personnel document signed by RN on May 17, 2023, indicated ULP-B needed to "follow oxygen orders, oxygen is not PRN." (PRN=as needed). The licensee's 2.37 Resident Record-Documentation policy dated July 19, 2021, indicated staff providing assisted living services will document daily, medications, services, treatments, or therapies provided to resident. Additionally, the policy indicated all documentation must include the signature and title of the person who performed the service or administered the medication, treatment, or therapy. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960			
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	02040			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39404	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/15/2023
NAME OF PROVIDER OR SUPPLIER SUITE LIVING SENIOR CARE OF SPRING LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 525 OSBORNE ROAD SPRING LAKE PARK, MN 55432		
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02040	Continued From page 38 by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on September 12, 2023, between approximately 12:30 p.m. and 12:45 p.m. with Regional Director of Operations (RDO)-E on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, RDO-E verified that the licensee had done a hazard vulnerability assessment for the following risks of the physical environment on and around the property: fish tank, fireplace, pond, busy roadway, retaining wall and fire extinguisher but failed to provide the mitigation piece for these risks. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040			

Minnesota Department of Health

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02310 SS=F	144G.91 Subd. 4 (a) 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 four of five residents who utilized a hospital bed rail (R2, R4, R9, and R10) by documenting measurements of entrapment zones at least every 90 days or with a change in condition. Additionally, licensee failed to ensure oxygen cylinders were properly stored for one of two residents (R8). 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: HOSPITAL BED RAIL/SIDE RAIL R2 R2 was admitted to licensee on December 28, 2022, with diagnoses of traumatic subdural hemorrhage with loss of consciousness (brain bleed), unsteadiness on feet, diabetes mellitus	02310			

Minnesota Department of Health

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02310	Continued From page 40 type 2, and disc degeneration of lumbar region. R2's Service Agreement signed December 28, 2022, indicated R2 received assistance with safety checks, laundry, housekeeping, medication administration, dressing and grooming, toileting, bathing, and transfers with a mechanical lift. R2's Bed Rail Assessment dated September 12, 2023, indicated R2 used two side rails. The assessment lacked zone entrapment measurements. R2's Side Rail Measurements document dated December 28, 2022, included zone entrapment measurements. On September 11, 2023, at 2:26 p.m., during an interview with R2, the surveyor observed a hospital bed with bilateral (2) upper side rails and bilateral lower side rails. This hospital bed was a Joerns brand where the side rails are not easily removeable. R2 stated his significant other purchased this bed privately and he utilized the upper side rails to promote independence. The upper side rails were attached firmly. The lower side rails were lowered. R4 R4 was admitted to licensee on May 8, 2023, with diagnoses of dementia, emphysema (lung disease), rheumatoid lung disease, and scoliosis. R4's Service Agreement signed August 16, 2023, indicated R4 received assistance with safety checks, laundry, medication administration, dressing and grooming, toileting, bathing, transfers, oxygen therapy, and wound care. R4's Bed Rail Assessment dated August 4, 2023,	02310		

Minnesota Department of Health

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02310	Continued From page 41 indicated R4 used two side rails. The assessment lacked zone entrapment measurements. R4's Side Rail Measurements document dated May 8, 2023, included zone entrapment measurements. R4's undated Weekly Bed Rail Inspection/Assessment included measurements, but it was unknown when the measurements were completed. On September 12, 2023, at 9:41 a.m., surveyor observed unlicensed personnel (ULP)-B and ULP-F enter R4's room to administer morning medications. R4 was sleeping in his hospital bed with bilateral upper side rails raised. R9 R9 was admitted to licensee on March 7, 2023, with diagnoses of progressive bulbar palsy (motor neuron disease), spastic hemiplegia (spasms to one side) affecting right dominate side, repeated falls, osteoporosis, and Raynaud's syndrome (reduced blood flow to an extremity temporarily). R9's Service Agreement signed August 22, 2023, indicated R9 received assistance with safety checks, modified diet, medication administration, dressing and grooming, bathing, and transfers. R9's Weekly Bed Rail Inspection/Assessment dated September 13, 2023, did not indicate how many side rails R9 used on her hospital bed. The assessment lacked zone entrapment measurements. R9's Side Rail Measurements document dated March 7, 2023, included zone entrapment measurements.	02310			

Minnesota Department of Health

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02310	Continued From page 42 On September 14, 2023, at 11:38 a.m., surveyor observed raised bilateral side rails attached to a hospital bed and both were securely attached. R10 R10 was admitted to licensee on December 26, 2022, with diagnoses of end stage heart failure, dementia, cataract (cloudy vision), low back pain, and bowel and bladder incontinence. R10's Service Agreement signed August 18, 2023, indicated R10 received assistance with safety checks, medication administration, dressing and grooming, bathing, compression socks, and transfers with a mechanical lift. R10's Bed Rail Assessment dated August 22, 2023, indicated R10 used two side rails. The assessment lacked zone entrapment measurements. R10's Side Rail Measurements document dated December 26, 2022, included zone entrapment measurements. On September 14, 2023, at 11:40 a.m., surveyor observed a hospital bed with bilateral raised side rails with purple color foam pool noodles attached with zip ties. R10 stated his son applied the foam pool noodles to help prevent injury to while moving in bed. On September 14, 2023, at 10:30 a.m., regional registered nurse (RN)-C stated during the weekly side rail assessment, the RN will check for proper installation and ensure the side rail(s) are secure, but the measurement of each side rail is done initially and annually.	02310			

Minnesota Department of Health

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02310	Continued From page 43 On September 14, 2023, at 10:40 a.m., regional director of operations (RDO)-E stated their sister facility had a side rail incident occur a few months ago and during their correction plan, they were not informed they were required to document measurements every 90 days or with a change in condition. RDO-E also stated their process was to obtain measurements initially when first used and annually. RDO-E also stated the licensee was informed if weekly side rail inspection would ensure the measurements did not change. RDO-E stated the licensee would include a location in the RN assessment to include measurements and on the weekly side rail assessment. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed	02310			

Minnesota Department of Health

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02310	Continued From page 44 without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's 6.28 Side Rails policy dated July 20, 2021, indicated the procedure to verify the side rail was safe was performed by ensuring side rails were used consistent with manufacturer's directions, installed securely, and side rail design was consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. The policy did not indicate how often the measurements were required to be checked. OXYGEN STORAGE	02310		

Minnesota Department of Health

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02310	Continued From page 45 On September 12, 2023, at 8:19 a.m., surveyor and ULP-B entered R8's apartment and surveyor observed one large oxygen cylinder standing unsecured near the entrance of the apartment door near a light switch and two small cylinders near R8's bed standing unsecured next to an electrical outlet. On September 13, 2023, at 10:26 a.m., surveyor showed clinical nurse supervisor (CNS)-A, R8's unsecured portable oxygen cylinders. CNS-A stated she would request hospice to send a crate to secure them. CNS-A also stated they were just delivered on Monday when R8 returned from the hospital. The Minnesota Department of Health Oxygen Cylinder Storage Requirements, dated April 16, 2020, stated, "cylinders must be secured (chains or racks) to prevent them from falling over." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310			



Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: 09/12/23
Time: 09:38:29
Report: 1023231184

Food and Beverage Establishment Inspection Report

Page 1

Location:

Suite Living Senior Care of SP
525 Osborne Road
Spring Lake Park, MN55432
Anoka County, 02

Establishment Info:

ID #: 0042040
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

2-400 Hygienic Practices

2-402.11

MN Rule 4626.0115 Food employees must wear an effective hair restraint, such as a hat, hair covering or hair net, a beard restraint and clothing to keep hair from contacting exposed food, clean equipment, utensils, linens, and unwrapped single-service or single-use articles.

OBSERVED LOOSE LONG HAIRS IN THE REACH IN COOLER. STAFF HANDLING FOOD MUST ALWAYS WEAR RESTRAINTS.

Comply By: 09/12/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

CLEAN HOOD FILTERS AS NEEDED. INSTALL GREASE TRAPS.

Comply By: 09/12/23

Surface and Equipment Sanitizers

Hot Water: = at 163 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

S&S: = 500PPM at Degrees Fahrenheit
Location: DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: 09/12/23
Time: 09:38:29
Report: 1023231184
Suite Living Senior Care of SP

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Cold Hold/REACH IN COOLER
Temperature: 40 Degrees Fahrenheit - Location: CUT MELON
Violation Issued: No

Process/Item: Cold Hold/PREP COOLER
Temperature: 41 Degrees Fahrenheit - Location: CUT TOMATO
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY HAS COMMERCIAL EQUIPMENT IN A MAIN KITCHEN AREA AND MEMORY CARE AREA. FOOD SERVICE IS PROVIDED BY CARE FACILITY STAFF.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED SHELL EGGS

FACILITY MUST ALWAYS HAVE PERSON IN CHARGE KNOWLEDGEABLE ABOUT FOOD SAFETY PRESENT FOR FOOD SERVICE. INSPECTOR STRONGLY RECOMMENDS HIRING ANOTHER KITCHEN STAFF PERSON AND/OR SENDING NURSING STAFF TO FOOD HANDLER TRAINING IS THEY ARE PROVIDING FOOD SERVICE.

ADJUST ANSUL SYSTEM AS NEEDED.

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 1023231184 of 09/12/23.

Certified Food Protection Manager: RAY BRAUN

Certification Number: 107463 Expires: 08/23/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

RAY BRAUN
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us