



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 19, 2023

Licensee
Mill Street Residence
802 South Mill Street
Fergus Falls, MN 56537

RE: Project Number(s) SL30317015

Dear Licensee:

On December 11, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 16, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Jessie Chenze'.

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 16, 2023

Licensee
Mill Street Residence
802 South Mill Street
Fergus Falls, MN 56537

RE: Project Number(s) SL30317015

Dear Licensee:

On October 10, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 16, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 16, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 16, 2023, found not corrected at the time of the October 10, 2023, follow-up survey and/or subject to penalty assessment are as follows:

1290-Background Studies Required-144g.60 Subdivision 1 - \$3,000.00

The details of the violations noted at the time of this follow-up survey completed on October 10, 2023 (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 \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with 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.

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 may challenge the correction order(s) 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 MDH 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 MDH 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.

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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.

Sincerely,

A handwritten signature in black ink that reads "Jessie Chenze". The signature is written in a cursive, flowing style.

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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 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: SL30317015-1 On October 9, 2023, through October 10, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 16, 2023. At the time of the survey, there were 63 residents; all of whom were receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	{0 110}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
{0 110}	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: No further action required.	{0 110}			
{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: (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}			
{0 620} SS=E	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the	{0 620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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	
{0 620}	Continued From page 2 common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The	{0 620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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	
{0 620}	Continued From page 3 lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: No further action required.	{0 620}			
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: No further action required.	{0 630}			
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number	{0 640}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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	
{0 640}	Continued From page 4 for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: No further action required.	{0 640}			
{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 residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	{0 680}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
{0 680}	Continued From page 5 This MN Requirement is not met as evidenced by: No further action required.	{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. (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.	{0 810}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
{0 810}	Continued From page 6	{0 810}			
{0 970} SS=C	This MN Requirement is not met as evidenced by: No further action required. 144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action required.	{0 970}			
{01290} SS=I	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 reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil	{01290}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
{01290}	Continued From page 7 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 current employee records contained all the required content to include a background study clearance letter for three of four employees (unlicensed personnel (ULP)-D, lead server (LS)-O, server (S)-CC). In addition, the licensee failed to affiliate employee background studies with the correct assisted living license for one of four employees (ULP-DD). This had the potential to affect all residents living within the facility. 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 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: BACKGROUND STUDY CLEARANCE ULP-D ULP-D was hired on April 11, 2017, and had begun working under the assisted living license effective August 1, 2021, to provide direct care to residents. On October 10, 2023, at 12:32 p.m., licensed assisted living director (LALD)-A stated ULP-D was currently working the day shift and was not under direct supervision.	{01290}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
{01290}	Continued From page 8 ULP-D's employee record contained a background study dated April 13, 2017, affiliated to the licensee's previous comprehensive license. LS-O LS-O was hired July 16, 2018, and had begun working under the assisted living license effective August 1, 2021, to provide dietary needs to residents. On October 10, 2023, at 12:36 p.m., LALD-A stated LS-O last worked on September 22, 2023, and would have been under direct supervision of other kitchen staff. LS-O's employee record contained a background study dated July 11, 2018, affiliated to the licensee's previous comprehensive license. S-CC S-CC was hired December 7, 2020, and had begun working under the assisted living license effective August 1, 2021, to provide dietary needs to residents. On October 10, 2023, at 12:35 p.m., LALD-A stated S-CC was an active employee, however, had not worked since July 13, 2023. S-CC's employee record contained a background study dated December 2, 2020, affiliated to the licensee's previous comprehensive license. On October 10, 2023, from 12:32 p.m. until 12:42 p.m., the NETStudy 2.0 Roster was reviewed with (LALD)-A and confirmed ULP-D, LS-O and S-CC were not listed on the licensee's NETStudy 2.0 Roster. LALD-A stated the licensee would not be able to be notified of an ineligible background study as the licensee could no longer access their	{01290}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
{01290}	Continued From page 9 previous comprehensive license Net Study 2.0 account as it had been deactivated or locked. BACKGROUND AFFILIATION ULP-DD ULP-DD was hired on April 10, 2023, to provide direct care to residents. ULP-D's record lacked documentation of a cleared background study affiliated with the facility's license. On October 10, 2023, at 12:38 p.m., LALD-A stated ULP-DD background study was not affiliated to the facility's license, however, was affiliated with a sister facility. The licensee's Competency Plan policy dated October 1992, indicated criminal background studies and fingerprinting must be completed on all employees who provide direct contact services in facilities licensed by the Minnesota Department of Health. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under	{01290}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
{01290}	Continued From page 10 continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information provided.	{01290}			
{01550} SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: No further action required.	{01550}			
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.	{01620}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
{01620}	Continued From page 11 (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action required.	{01620}			
{01760} SS=D	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.	{01760}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
{01760}	Continued From page 12	{01760}			
	This MN Requirement is not met as evidenced by: No further action required.				
{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: No further action required.	{01960}			
{02310} SS=D	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: No further action required.	{02310}			
{03000} SS=E	626.557 Subd. 3 DO NOT USE / Timing of report	{03000}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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	
{03000}	Continued From page 13 (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect	{03000}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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	
{03000}	Continued From page 14 according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: No further action required.	{03000}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 5, 2023

Licensee
Mill Street Residence
802 South Mill Street
Fergus Falls, MN 56537

RE: Project Number(s) SL30317015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 16, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be 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.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The MDH may impose 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 MDH 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 (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 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with 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 resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) 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 MDH 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 MDH 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 state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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: SL30317015-0 On August 14, 2023, through August 16, 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 60 active residents; 59 of whom were receiving services under the Assisted Living license. An immediate correction order was identified on August 15, 2023, issued for SL30317015-0, tag identification 1290. On August 15, 2023, at 4:35 p.m., the immediacy of correction order 1290 was removed, however, non-compliance remained at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level 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: During the entrance conference on August 14, 2023, LALD-A identified himself as the current LALD for the licensee. On August 14, 2023, at 9:18 a.m., the surveyor reviewed the Board of Executives for Long-Term Services and Support (BELTSS) website with LALD-A. The BELTSS website indicated LALD-A had an assisted living director license (effective May 6, 2021; expires October 31,2023). The website did not indicate LALD-A as the Director of Record for the licensee, this section was left blank. LALD-A stated he was unaware the Director of Record needed to be listed on the BELTSS website.	0 110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
0 110	Continued From page 2 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
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: (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 August 14, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 620 SS=E	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
0 620	Continued From page 3 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) an unwitnessed fall with injury for three of three residents (R7, R8, R9). 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: R7 R7's diagnoses included hypertension (HTN-high blood pressure), amputation at left midfoot, gait disturbance (unsteady balance), and anxiety. R7's service plan dated May 27, 2023, indicated R7 received assistance with medication reminders, bathing, toileting, and escorts. R7's record contained the following falls reports: -March 9, 2023, at 10:50 a.m., R7 had an unwitnessed fall and was found on floor by	0 620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
0 620	Continued From page 4 unidentified staff. Unidentified staff indicated R7 lost balance. R7 had lump on back of head/ice applied to area. Primary physician was updated via fax. -April 3, 2023, at 11:30 p.m., R7 had an unwitnessed fall and was found on floor by an unidentified staff. Unidentified staff indicated R7 lost balance on a wet bathroom floor and R7 landed on bottom. Primary physician was updated via fax. -April 8, 2023, at 3:15 p.m., R7 had an unwitnessed fall and was found on floor in the licensee's community dining room by an unidentified staff. Unidentified staff indicated R7 hit her head and a hematoma (bruise)/small [sic] to back of head. Primary physician was updated via fax. -April 12, 2023, at 5:15 a.m., R7 had an unwitnessed fall and was found on floor by unidentified staff. Unidentified staff indicated R7 lost balance and fell to the floor. R7 injuries included R7 hit back of head and abrasion on R7's back between the shoulder blades. Primary physician was updated via fax. -April 27, 2023, at 3:05 a.m., R7 was found on floor by unidentified staff. Unidentified staff indicated R7 slid out of left chair attempting to stand to get to the bathroom. No injury occurred. -April 27, 2023, at 3:15 a.m., R7 had a witnessed fall by unidentified staff. R7 lost balance while walking with walker. R7 had a chin laceration, right bridge of nose laceration, right eyebrow laceration, mouth trauma, teeth knocked out, and left elbow and ear skin tears. Unidentified staff applied pressure to face lacerations. Resident was seen and evaluated in ED (emergency department). -May 1, 2023, at 6:45 p.m., R7 had an unwitnessed fall. R7 pushed alarm, unidentified staff found R7 on kitchen floor, on her back with	0 620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
0 620	Continued From page 5 walker tipped over to the side. R7 stated "I may be bumped my head." Contributing factors included impaired balance and impaired judgement. Injury occurred on right forearm skin tear. Cleansed skin tear with soap and water, applying steri stirps, gauze and tegaderm. Primary physician was updated via fax. R8 R8's diagnoses included back pain, hypothyroidism (underactive thyroid), and depression with anxiety. R8's service plan dated, June 10, 2023, indicated R8 received assistance with medication set-ups, medication reminders and bathing. R8's record contained the following fall report: -April 13, 2023, at 6:20 a.m., R8 had an unwitnessed fall and was found on the floor by unidentified staff. R8 did not know what happened. R8 had injury to right hip and was sent to the ED. Primary physician was updated via fax. R8's record contained the following progress note: -April 13, 2023, at 3:20 p.m., progress note by registered nurse (RN)-BB noted "returned from ED with no findings related to injury from fall. White blood cells was increased and started on an antibiotic therapy. Is weak, confused, and requires increased assistance, daughter present." R9 R9's diagnoses included kidney cancer, osteoarthritis (breakdown of cartilage in joints), and gastroesophageal reflux disease (acid reflux). R9's service plan dated, March 11, 2023,	0 620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
0 620	Continued From page 6 indicated R9 received assistance with medication set-ups, medication reminders, bathing, and morning and evening cares. R9's record contained the following fall report: -March 24, 2023, at 7:50 p.m., R9 had an unwitnessed fall and was found by unidentified staff in her apartment on the floor in sitting position with walker tipped over to the left of her. R9 has left cheekbone and facial swelling, and left knee pain with swelling. Report did not indicate if resident knew how she fell. Nurse and family was notified. Ice pack was placed on facial swelling and was sent to ED. Primary physician was updated via fax. R9's record contained the following progress note: -March 25, 2023, at 9:30 a.m., RN-BB noted "post fall/ED return, left eye hematoma, mild swelling. Left knee is swollen with minimal abrasions and are stable. Has been taking as needed (PRN) Tylenol. Stiff and sore, favoring left leg, unsteady gait, assist with mobility, daughter present." On August 16, 2023, at 10:38 a.m., clinical nurse supervisor (CNS)-B stated a reportable MAARC report would include abuse, elopement, and unexplained injuries. CNS-B stated no MAARC reports were made for the above noted unwitnessed falls with injury since the residents were able to explain how each fall occurred. CNS-B further stated all MAARC reports should be reported immediately or within 24 hours. The licensee's Vulnerable Adult policy dated July 1993, indicated mandated reports include unexplained injuries.	0 620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
0 620	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three residents (R2, 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 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:	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
0 630	Continued From page 8 R2 R2's diagnoses included mild cognitive impairment, anxiety, and hypertension (high blood pressure). R2's service plan dated, March 8, 2023, indicated the resident received services which included medication reminders, bathing, and escort services. On August 14, 2023, at 9:41 a.m., the surveyor observed unlicensed personnel (ULP)-C escort R2 to exercise class. R2's Vulnerability, Safety, and Risk Assessment (IAPP) dated January 31, 2023, identified areas of vulnerability with interventions and a review of the resident's risk of abusing other vulnerable adults. R2's IAPP did not include risk of susceptibility to be abused by another individual, including other vulnerable adults. R3 R3's diagnoses include mild mental retardation, hypothyroidism (underactive thyroid) and anxiety. R3's service plan dated March 2, 2020, indicated the resident received services which included medication administration, assistance with continuous positive airway pressure (CPAP), and assistance applying compression stockings (TEDS). On August 14, 2023, at 9:30 a.m., the surveyor observed ULP-C administer medications and apply TEDS. R3's Vulnerability, Safety, and Risk Assessment (IAPP) dated July 27, 2023, identified areas of	0 630		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
0 630	Continued From page 9 vulnerability with interventions and a review of the resident's risk of abusing other vulnerable adults. R3's IAPP did not include risk of susceptibility to be abused by another individual, including other vulnerable adults. R4 R4's diagnoses included diabetes, asthma, and hyperlipidemia (elevated fat particles in blood). R4's service plan dated August 15, 2023, indicated the resident received services which included medication administration, blood glucose monitoring, and assistance applying TEDS. On August 15, 2023, at 7:47 a.m., the surveyor observed ULP-D administer R4's scheduled morning medications. R4's Vulnerability, Safety, and Risk Assessment (IAPP) dated May 5, 2023, identified areas of vulnerability with interventions and a review of the resident's risk of abusing other vulnerable adults. R4's IAPP did not include risk of susceptibility to be abused by another individual, including other vulnerable adults. On August 16, 2023, at 10:21 a.m., clinical nurse supervisor (CNS)-B stated all resident records contain the same IAPP form and was missing the risk of susceptibility to be abused by others. The licensee's Vulnerable Adult policy dated April 2022, indicated upon admission, each resident receiving services will be assessed as to their vulnerability. This assessment will be documented on the appropriate form. Assessment will include an abuse prevention plan for any vulnerabilities identified.	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
0 630	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required information in the commons area to include posting the 911 emergency number, and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had the potential to affect all 60 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	0 640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
0 640	Continued From page 11 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 14, 2023, at 10:25 a.m., the surveyor and licensed assisted living director (LALD)-A observed the commons area and facility entrance for the required 911 emergency number, and reporting number for MAARC. LALD-A stated the numbers were not posted in the commons area or main entry of the facility, and asked if other facilities had this information posted. He was not aware of this requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
0 680	Continued From page 12 missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have all the written requirements in the emergency preparedness plan (EPP) as defined in Appendix Z (a section of the Centers for Medicare and Medicaid Services (CMS) state operations manual which includes the emergency preparedness guidelines). In addition, the licensee failed to ensure it's missing resident policy was reviewed quarterly as referred under section 4659.0110. This had the potential to affect all residents, staff and visitors 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: EMERGENCY PREPAREDNESS PLAN	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
0 680	Continued From page 13 The licensee's undated EPP had a collection of a risk analysis tool, communication plan, resident population, a collaboration process, various policies and other required information. However, the EPP lacked a shelter in place policy and procedure. MISSING RESIDENT PLAN Contained in the licensee's EPP was the licensee's undated Missing Resident policy, which lacked documentation the Missing Resident policy had been reviewed at least quarterly by licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B. On August 14, 2023, at 12:05 p.m., LALD-A stated the EPP did not contain a shelter in place policy, and he thought it was covered in the EPP. On August 14, 2023, at 12:35 p.m., CNS-B stated the missing resident plan was not reviewed quarterly. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. 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	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
0 810	Continued From page 14 (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 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, failed to provide required employee and resident training	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
0 810	Continued From page 15 on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on August 16, 2023, at approximately 11:15 a.m. with licensed assisted living director (LALD)-A 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 evacuation plan did not include procedures for residents evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The current plan shows procedures for residents movement, but does not get into the whole evacuation and relocation process. Record review of the available documentation indicated that the licensee provided training for employees on the fire safety and evacuation plans upon hire, but not at least twice per year thereafter. Record review of the available documentation	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
0 810	Continued From page 16 indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month for employees as required by statute. LALD-A indicated that employees were conducting fire drills twice per year per shift and every other month but not adding in the evacuation piece. During interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the 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 one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
0 970	Continued From page 17 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: During the entrance conference on August 14, 2023, at 9:45 a.m., the surveyor asked for a copy of the licensee's assisted living contract. The assisted living contract was provided and later reviewed by the surveyor. The assisted living contract provided included a clause that indicated the resident would waive the facility's liability for health, safety, or personal property of the resident. Page 15, section 26. LIMITATION OF LIABILITY: Resident does hereby release and agree to hold harmless (facility name) for any liability, loss, damage, cost or expense, including but not limited to attorney fees or cost of litigation relating to any injury or loss of any kind suffered by the person or property of the resident. Resident agrees to indemnify (facility name) of any costs or damages incurred by (facility name) for any injury to the person or property of (facility name) or others arising from the actions of the resident... Resident acknowledges and agrees that the health and medical care of the resident is the resident's sole responsibility and (facility name) shall in no event incur liability arising out of the acts or failure to act of its partners, officers, directors, agents, servants or employees, nor shall any of (facility name) partners, officers, directors, agents, servants or employees be liable for any act or failure to act. Resident and sponsor do hereby release and agree to hold harmless (facility name) and (facility name) employees from any	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
0 970	Continued From page 18 liability, loss, damage, cost or expense, including but not limited to health care, attorney fees and costs of litigation relating to any injury or loss of any kind suffered by resident, including, but not limited to, that which is due to disorientation and/or refusal to stay on the premises. On August 14, 2023, at 11:33 a.m., licensed assisted living director (LALD)-A stated the licensee provided the same assisted living contract to all residents. LALD-A reviewed the Limitation of Liability section and stated, "it (the Limitation of Liability section) sounds like waiving liability to me." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970			
01290 SS=I	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 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.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
01290	Continued From page 19 This MN Requirement is not met as evidenced by: ****REVISED**** On August 16, 2023, added provider's policy to order. Based on observation, interview and record review, the licensee failed to ensure current employee records contained all the required content to include a background study clearance letter for six of eight employees (unlicensed personnel (ULP)-C, maintenance (M)-E, business office assistant (BOA)-G, licensed practical nurse (LPN)-H, lead cook (LC)-L, ULP-T). In addition, the licensee failed to affiliate employee background studies with the correct assisted living license for 16 of 52 employees (ULP-D, ULP-F, server (S)-I, ULP-J, ULP-K, ULP-M, dining service supervisor (DSS)-N, lead server (LS)-O, ULP-P, ULP-Q, LC-R, business office manager (BOM)-S, ULP-U, cook (C)- V, ULP-W, housekeeping (HSKP)-X, HSKP-Y). This had the potential to affect all residents living within the facility. 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 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: This resulted in an immediate correction order on August 15, 2023, at approximately 3:15 p.m.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
01290	Continued From page 20 BACKGROUND STUDY CLEARANCE ULP-C ULP-C was hired on January 27, 2012, and had begun working under the assisted living license effective August 1, 2021, to provide direct care to residents. On August 14, 2023, at 9:20 a.m., the surveyor observed ULP-C provide scheduled morning medication administration to R3. ULP-C was not under direct supervision. ULP-C's employee record contained a cleared background study dated February 2, 2012. On August 15, 2023, at 11:25 a.m., the Net Study 2.0 Roster was reviewed with licensed assisted living director (LALD)-A and confirmed ULP-C was not listed on the Net Study 2.0 Roster and ULP-C employee record did not contain a cleared background study after February 2, 2012. On August 15, 2023, at 2:30 p.m., human resource manager (HRM)-AA stated ULP-C does not have a current cleared background study on Net Study 2.0. M-E M-E was hired on October 1, 1997, and had begun working under the assisted living with dementia care license effective August 1, 2021, to provide maintenance upkeep to the buildings. On August 15, 2023, throughout the morning and afternoon, the surveyor observed M-E in and out of the assisted living providing maintenance and conversing with residents. M-E was not observed to be under direct supervision.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
01290	Continued From page 21 M-E's record lacked documentation of a cleared background study. On August 15, 2023, at 10:43 a.m., LALD-A stated M-E was employed full-time by licensee. BOA-G BOA-G was hired June 18, 2008, and had begun working under the assisted living license effective August 1, 2021. BOA-G's record lacked documentation of a cleared background study. On August 15, 2023, at 2:28 p.m., HRM-AA stated BOA-G does not have a current cleared background study on Net Study 2.0. LPN-H LPN-H was hired was hired May 8, 2006, and had begun working under the assisted living license effective August 1, 2021, to provide direct care to residents. LPN-H's record lacked documentation of a cleared background study. On August 15, 2023, at 2:28 p.m., HRM-AA stated LPN-H does not have a current cleared background study on Net Study 2.0. LC-L LC-L was hired February 14, 2011, and had begun working under the assisted living license effective August 1, 2021, to provide dietary needs. LC-L's record lacked documentation of a cleared background study affiliated with the facility's license.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
01290	Continued From page 22 On August 15, 2023, at 2:29 p.m., HRM-AA stated LC-L does not have a current cleared background study on Net Study 2.0. ULP-T ULP-T was hired on September 16, 1995, and had begun working under the assisted living license effective August 1, 2021, to provide direct care to residents. ULP-T's record lacked documentation of a cleared background study. On August 15, 2023, at 2:25 p.m., HRM-AA stated ULP-T does not have a current cleared background study on Net Study 2.0. BACKGROUND AFFILIATION ULP-D ULP-D was hired on April 11, 2017, and had begun working under the assisted living license effective August 1, 2021, to provide direct care to residents. On August 15, 2023, at 7:47 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R4. ULP-D's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-F ULP-F was hired on February 17, 2020, and had begun working under the assisted living license effective August 1, 2021, to provide direct care to residents.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
01290	Continued From page 23 ULP-F's record lacked documentation of a cleared background study affiliated with the facility's license. S-I S-I was hired January 21, 2019, and had begun working under the assisted living license effective August 1, 2021, to provide dietary needs. S-I's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-J ULP-J was hired on March 21, 2016, and had begun working under the assisted living license effective August 1, 2021, to provide direct care to residents. ULP-J's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-K ULP-K was hired on May 2, 2022, to provide direct care services to the residents. ULP-K's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-M ULP-M was hired on February 15, 2021, and had begun working under the assisted living license effective August 1, 2021, to provide direct care to residents. ULP-M's record lacked documentation of a cleared background study affiliated with the facility's license.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
01290	Continued From page 24 DSS-N DSS-N was hired October 19, 2015, and had begun working under the assisted living license effective August 1, 2021, to provide dietary needs. DSS-N's record lacked documentation of a cleared background study affiliated with the facility's license. LS-O LS-O was hired July 16, 2018, and had begun working under the assisted living license effective August 1, 2021, to provide dietary needs. LS-O's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-P ULP-P was hired on November 16, 2020, and had begun working under the assisted living license effective August 1, 2021, to provide direct care to residents. ULP-P's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-Q ULP-Q was hired on January 12, 1998, and had begun working under the assisted living license effective August 1, 2021, to provide direct care to residents. ULP-Q's record lacked documentation of a cleared background study affiliated with the facility's license. LC-R	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
01290	Continued From page 25 LC-R was hired July 30, 2002, and had begun working under the assisted living license effective August 1, 2021, to provide dietary needs. LC-R's record lacked documentation of a cleared background study affiliated with the facility's license. BOM-S BOM-S was hired April 20, 2015, and had begun working under the assisted living license effective August 1, 2021. BOM-S's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-U ULP-U was hired on August 22, 2012, and had begun working under the assisted living license effective August 1, 2021, to provide direct care to residents. ULP-U's record lacked documentation of a cleared background study affiliated with the facility's license. C-V C-V was hired January 21, 2019, and had begun working under the assisted living license effective August 1, 2021, to provide dietary needs. C-V's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-W ULP-W was hired on November 30, 2020, and had begun working under the assisted living license effective August 1, 2021, to provide direct	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
01290	Continued From page 26 care to residents. ULP-W's record lacked documentation of a cleared background study affiliated with the facility's license. HSKP-X HSKP-X was hired July 6, 2020, and had begun working under the assisted living license effective August 1, 2021, to provide HSKP needs to residents. HSKP-X's record lacked documentation of a cleared background study affiliated with the facility's license. HSKP-Y HSKP-Y was hired January 27, 2011, and had begun working under the assisted living license effective August 1, 2021, to provide HSKP needs to residents. HSKP-Y's record lacked documentation of a cleared background study affiliated with the facility's license. The surveyor reviewed the licensee's Net Study 2.0 Roster with the correct HFID provided by the facility and verified the employees listed above were not affiliated with the correct HFID. On August 15, 2023, at 11:25 a.m., LALD-A confirmed the above employees were employed at the facility. On August 15, 2023, at 11:30 a.m., human resource coordinator (HRC)-Z stated she recently started completing background studies and would have to check with the manager and get back to the surveyor in regard to how the facility would be	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
01290	Continued From page 27 notified if a background check came back disqualified. On August 15, 2023, at 2:18 p.m., HRM-AA stated the above employees were not affiliated with the correct license prior to August 15, 2023. The licensee's Competency Plan policy dated October 1992, indicated criminal background studies and fingerprinting must be completed on all employees who provide direct contact services in facilities licensed by the Minnesota Department of Health. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
01290	Continued From page 28 No further information provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveyor supervisor on August 15, 2023, at 4:35 p.m., however, non-compliance remains at a scope and level of three, widespread (I).	01290		
01550 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees not providing direct care received at least two hours of annual dementia training for one of one employee (maintenance (M)-E). 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).	01550		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
01550	Continued From page 29 The findings include: During the entrance conference on August 14, 2023, at 9:19 a.m., licensed assisted living director (LALD)-A stated the licensee provided services to residents with diagnoses of related disorders to dementia. M-E was hired on October 1, 1997, and had begun working under the assisted living license effective August 1, 2021, to provide maintenance upkeep to the buildings. On August 15, 2023, throughout the morning and afternoon, the surveyor observed M-E in and out of the assisted living providing maintenance and conversing with residents. M-E's employee record lacked evidence M-E completed at least two hours of training on topics related to dementia care for each 12 months of employment thereafter. On August 16, 2023, at 10:19 a.m., clinical nurse supervisor (CNS)-B stated the licensee goes by calendar year of January 1 through December 31 to track employee trainings. CNS-B stated M-E did not have any dementia training for calendar year of 2022. The licensee's Assisted Living Dementia Training policy dated August 1, 2021, indicated non-direct care employees will have a minimum of two hours training on topics related to dementia for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
01550	Continued From page 30 (21) days	01550			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a change in condition assessment for three of three residents (R7, R8, R9) with falls. In addition, the licensee failed to ensure a RN conducted assessments using the uniform assessment tool that included	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
01620	Continued From page 31 all required content for one of one resident (R4). 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: CHANGE OF CONIDITION ASSESSMENT R7 R7's diagnoses included hypertension (HTN-high blood pressure), amputation at left midfoot, gait disturbance (unsteady balance), and anxiety. R7's service plan dated May 27, 2023, indicated R7 received assistance with medication reminders, bathing, toileting, and escorts. R7's record contained the following fall report and progress note for fall #1 identified: -April 2, 2023, at 10:55 a.m., R7 had an unwitnessed fall and was found on floor by an unidentified staff. No injury occurred. Contributing factors indicated poor footwear, improper use of assisted device, and lost or impaired balance. Primary physician updated via fax. -April 2, 2023, at 3:30 p.m., indicated follow up on R7 fall. Safety awareness is poor as R7 throws herself back in recliner chair. Conversation about doing that more careful. Vital signs obtained per RN. R7's record contained the following fall report and progress note for fall #2 identified: -April 3, 2023, at 11:30 p.m., R7 had an	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
01620	Continued From page 32 unwitnessed fall and was found on floor by an unidentified staff. Unidentified staff indicated R7 lost balance on a wet bathroom floor and R7 landed on bottom. Contributing factors indicated poor footwear and lost or impaired balance. Primary physician was updated via fax. -April 4, 2023, at 9:30 a.m., indicated follow up on R7 fall. Denies no injury and vital signs obtained per RN. R7's record contained the following fall report for fall #3 identified: April 8, 2023, at 3:15 p.m., R7 had an unwitnessed fall and was found on floor in the licensee's community dining room by an unidentified staff. Unidentified staff indicated R7 hit her head and a hematoma (bruise)/small [sic] to back of head. Contributing factors indicated compulsive and poor safety awareness. Primary physician was updated via fax. R7's record contained the following progress notes for fall #4 identified: -April 11, 2023, at 12:00 p.m., indicated R7 was found leaning up against the wall across from the refrigerator. R7 stated that her left foot got stuck and she fell. Kitchen floor noted to be quite sticky and R7 stated that she had spilled something on it last night. R7 hit her head on the floor and has a small hematoma and laceration. Ice applied and bleeding stopped without difficulty. R7 assisted off the floor with assist of 2 staff. R7 had small abrasions to both knees. R7 assisted to the bathroom and back to R7 recliner to eat lunch per RN. -April 11, 2023, at 11:45 p.m., indicated R7 complains of feeling dizzy and nauseated. R7 laying in recliner. R7 stated she ate some plums and threw up. R7 does have recurrent emesis due to hiated [sic] hernia. R7 does have head	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
01620	Continued From page 33 injury from recent fall. Denied being lightheaded at rest and only when R7 walks. Encouraged R7 to call for assist if feeling dizzy. Vital signs obtained per unidentified staff. R7's record contained the following fall report and progress note for fall #5 identified: -April 12, 2023, at 5:15 a.m., R7 had an unwitnessed fall and was found on floor by unidentified staff. Unidentified staff indicated R7 lost balance and fell to the floor. R7 injuries included R7 hit back of head and abrasion on R7's back between the shoulder blades. Contributing factor indicated impaired balance. Primary physician was updated via fax. -April 12, 2023, at 10:00 a.m., indicated follow up on R7 fall. Laceration on left scalp is covered with dry blood. Again, discussed R7 safety. Vital signs obtained per RN. R7's record contained the following progress notes for fall #6 identified: -April 20, 2023, at 6:40 p.m., indicated R7 had a fall after R7 lost balance attempting to hang up phone in kitchen. 1.5 inch laceration to left knee. R7's daughter transport to ED (emergency department). R7 had inappropriate footwear and poor safety awareness. Vital signs obtained and reminder set in calendar for nursing to assess affected area tomorrow per unidentified staff. -April 21, 2023, at 9:30 a.m., indicated follow up on R7 fall. Incident reviewed. Conversation held "re: proper footwear." Band-Aid changed on left knee- stitches intact. Vital signs obtained per RN. R7's record contained the following progress notes for fall #7 identified: -April 21, 2023, at 8:00 p.m., indicated R7 slipped out of chair while trying to pick up a blanket. Two unlicensed personnel (ULP) assisted R7 with a	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
01620	Continued From page 34 gait belt. R7 denies hitting head. R7 had 3 small rug burns to left elbow forearm area. Vital signs obtained per ULP. -April 23, 2023, at 10:00 a.m., indicated follow up post fall for R7. Vital signs obtained. R7 denied pain and observed to be wearing gripper socks on feet. R7 reminded of safety practices per RN. R7's record contained the following fall report and progress notes for fall #8 identified: -April 25, 2023, at 12:40 p.m., R7 was found on floor by an unidentified staff. R7 was trying to hang a pair of pants on the back of the chair and reached to far, lost her balance, and went down on one knee. No injury occurred. Contributing factors indicated R7 reached out too far and lost her balance. Primary physician updated via fax. -April 25, 2023, at 7:15 p.m., indicated follow up on R7 fall. Denies no injury. Vital signs obtained per RN. -April 26, 2023, at 5:30 p.m., indicated met with R7 and family to discuss falls and care needs. Agreed to have assist with all transfers and toileting in order to reduce fall risk per CNS-B. R7's record contained the following fall reports and progress notes for fall #9 and #10 identified: -April 27, 2023, at 3:05 a.m., R7 was found on floor by unidentified staff. Unidentified staff indicated R7 slid out of left chair attempting to stand to get to the bathroom. No injury occurred. -April 27, 2023, at 3:15 a.m., R7 had a witnessed fall by unidentified staff. R7 lost balance while walking with walker. R7 had a chin laceration, right bridge of nose laceration, right eyebrow laceration, mouth trauma, teeth knocked out, and left elbow and ear skin tears. Unidentified staff applied pressure to face lacerations. Contributing factors indicated impaired balance. Resident was seen and evaluated in ED.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
01620	Continued From page 35 -Fall Screening dated April 27, 2023, indicated R7 was frequently unsteady, needs assistance, noted weakness in ambulation, had 3 or more falls in the last 6 months, and needs reminders to use assistive device. Further indicated high risk for falls, remind to always use walker at all times, services put in place for escorts, transferring and toileting. -April 27, 2023, at 8:50 a.m., indicated R7 returned from ED by daughter. Has moderate amount of ecchymosis on face. Conversation to increase services. Agrees to do so. Vital signs obtained per RN. R7's record contained the following fall report and progress note for fall #11 identified: -April 30, 2023, at 4:10 a.m., R7 was found on floor laying on her back. R7 fell out of chair when leaning over to pull up stocking. No injury occurred. Contributing factors indicated impaired balance. Primary physician was updated via fax. -April 30, 2023, at 3:45 p.m., indicated follow up on R7 fall. Discussed R7 safety. Vital signs obtained per RN. R7's record contained the following fall report and progress note for fall #12 identified: -May 1, 2023, at 6:45 p.m., R7 had an unwitnessed fall. R7 pushed alarm, unidentified staff found R7 on kitchen floor, on her back with walker tipped over to the side. R7 stated "I may be bumped my head." Contributing factors included impaired balance and impaired judgement. Injury occurred on right forearm skin tear. Cleansed skin tear with soap and water, applying steri stirps, gauze and tegaderm. Primary physician was updated via fax. -May 2, 2023, at 10:00 a.m., indicated follow up on R7 fall. No complaints of pain. Able to stand and transfer without difficulty. Dressing to right	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
01620	Continued From page 36 forearm clean, dry, intact. Again, stressed the importance of calling for help with transfers to prevent falls per CNS-B. R7's record contained the following fall report for fall #13 identified: -May 20, 2023, at 2:00 p.m., R7 had an unwitnessed fall and was found at the foot of R7 bed. R7 stated to unidentified staff she was reaching for her paperwork, which was located next to the chair. Contributing factors included non-compliant-was instructed to use c/a (call light) for assist. No injury occurred. Primary physician was updated via fax. R8 R8's diagnoses included back pain, hypothyroidism (underactive thyroid), and depression with anxiety. R8's service plan dated, June 10, 2023, indicated R8 received assistance with medication set-ups, medication reminders and bathing. R8's record contained the following fall report: -April 13, 2023, at 6:20 a.m., R8 had an unwitnessed fall and was found on the floor by unidentified staff. R8 did not know what happened. R8 had injury to right hip and was sent to the ED. Primary physician was updated via fax. R8's record contained the following progress note: -April 13, 2023, at 3:20 p.m., progress note by registered nurse (RN)-BB noted "returned from ED with no findings related to injury from fall. White blood cells was increased and started on an antibiotic therapy. Is weak, confused, and requires increased assistance, daughter present."	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
01620	Continued From page 37 R9 R9's diagnoses included kidney cancer, osteoarthritis (breakdown of cartilage in joints), and gastroesophageal reflux disease (acid reflux). R9's service plan dated, March 11, 2023, indicated R8 received assistance with medication set-ups, medication reminders, bathing, and morning and evening cares. R9's record contained the following fall report: -March 24, 2023, at 7:50 p.m., R9 had an unwitnessed fall and was found by unidentified staff in her apartment on the floor in sitting position with walker tipped over to the left of her. R9 has left cheekbone and facial swelling, and left knee pain with swelling. Report did not indicate if resident knew how she fell. Nurse and family was notified. Ice pack was placed on facial swelling and was sent to ED. Primary physician was updated via fax. R9's record contained the following progress note: -March 25, 2023, at 9:30 a.m., RN-BB noted "post fall/ED return, left eye hematoma, mild swelling. Left knee is swollen with minimal abrasions and are stable. Has been taking as needed (PRN) Tylenol. Stiff and sore, favoring left leg, unsteady gait, assist with mobility, daughter present." R7, R8, and R9's records lacked evidence the RN reassessed for a change of condition on R7, R8, and R9 after unwitnessed falls and failed to develop and implement fall prevention interventions. On August 16, 2023, at 10:16 a.m., CNS-B stated	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
01620	Continued From page 38 following an unwitnessed fall, a focused assessment should be completed and interventions would be put in place. In addition, CNS-B stated a RN did not complete an assessment after falls, including interventions to prevent future falls, for R7, R8, or R9. The licensee's Falls Prevention and Reduction policy dated August 2021, indicated the RN will conduct a falls assessment, evaluate potential interventions to reduce or eliminate the risk, educate the resident and/or the resident's representative and make recommendations for preventative actions the resident can take such as physical therapy, and exercise. In additional, an interdisciplinary falls prevention team will monitor and address resident-related falls. This team will meet on an ongoing and as needed basis to review, discuss and initiate potential remedies for any resident experiencing multiple falls (2 or more falls within 30 days or 3 or more falls within 3 months). UNIFORM ASSESSMENT TOOL R4's diagnoses included diabetes, asthma, and hyperlipidemia (elevated fat particles in blood). On August 15, 2023, at 7:47 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R4. R4's Nursing Visit Notes were completed May 19, 2023, and July 20, 2023, respectively. R4's Nursing Visit Notes (identified as assessments), lacked the required content from the uniform assessment tool as identified in Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Subp. 2.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
01620	Continued From page 39 On August 16, 2023, at 10:28 a.m., CNS-B stated the same assessment was used for all residents and was not aware of the uniform assessment tool required for assessments at least every 90 days. The licensee's Initial and Ongoing Nursing Assessment policy dated August 1, 2021, indicated a comprehensive assessment includes, but may not be limited to the requirements outlined by Minnesota rules including: -the resident's personal lifestyle preferences including spiritual and cultural preferences, advance health care directives and end-of-life preferences; -activities of daily living including toileting pattern, bowel, and bladder control, dressing, grooming, bathing, and personal hygiene, dental status, oral care, housework, laundry, and transportation; -physical health status including allergies, sensitivities related to medication, seasonality, environment, and food, infectious conditions, review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements for each: - the reason taken; -any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; -the dosage; -the frequency of use; -the route administered or taken; -any difficulties the resident faces in taking the medication; -whether the resident self-administer the medication; -the resident's preferences in how to take medication;	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
01620	Continued From page 40 -intervention needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medication; and -provide instructions to the resident and the resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. -a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from postacute care facility; -effective medication treatment and nonmedication interventions; -communication and sensory capabilities including speech, assistive communication and sensory devices including hearing aids, and the ability to understand and be understood; -nutritional and hydration status and preferences; - list of treatments, including type, frequency, and level of assistance needed; -nursing needs, including potential to receive nursing-delegated services; and -risk indications including: -emergency evacuation ability; -complex medication regimen; -risk for dehydration, including history of urinary tract infections and current fluid intake pattern; -unsuccessful prior placements; -elopement risk including history or previous elopements; -smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and -alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
01620	Continued From page 41 In addition, the policy indicated an RN will complete a comprehensive nursing assessment of the physical, mental and cognitive needs as required: Pre-admission assessment, 14-day assessment (completed up to 14 days after start of services) ongoing assessment (completed periodically but no less than every 90 days) and change of resident condition. Minnesota Rules - Assisted Living Facilities 4659.0150 subpart 2, Assessment tool elements, indicated each facility must develop a uniform assessment tool. The facility may use an acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01760 SS=D	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	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
01760	Continued From page 42 with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of one resident (R4) who received medication management services. In addition, the licensee failed to ensure the steps of the medication administration process was followed for one of two employees (unlicensed personnel ((ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 14, 2023, at 9:24 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. MEDICATION NOT ADMINISTERED R4's diagnoses included diabetes, asthma, and hyperlipidemia (elevated fat particles in blood). R4's service plan dated December 22, 2021, indicated the resident received services which included medication administration, and blood glucose monitoring. R4's prescriber orders dated May 5, 2023,	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
01760	Continued From page 43 included an order for glucose 15 grams (gm) tablet- take 4 tablets orally as needed for blood sugar readings less than 70. On August 16, 2023, at 10:33 a.m., the surveyor reviewed R4's Blood Glucose Record and R4's Medication Sheet dated July 2023, with CNS-B and confirmed the following: -July 8, 2023, before breakfast, R4's blood glucose was 63. Glucose tablets were not administered; and -July 15, 2023, before breakfast, R4's blood glucose was 62. Glucose tablets were not administered. On August 16, 2023, at 10:34 a.m., CNS-B stated glucose tablets should have been administered to R4 or written documentation of why the glucose tablets were not administered. MEDICATION ADMINISTRATION PROCESS On August 15, 2023, at 7:26 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R11. ULP-D compared the prescription label with the medication administration record (MAR), placed the medications into a paper cup, documented on the MAR that medications were administered, and then observed the medications being taking by R11. On August 15, 2023, at 7:47 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R4. ULP-D compared the prescription label with the MAR, placed the medications into a paper cup, documented on the MAR that medications were administered, and then observed R4 take the medications. Immediately following the observation, ULP-D stated that medications were	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
01760	Continued From page 44 documented as given before the residents actually took the medication and that was the normal routine ULP-D used during the medication administration process. On August 15, 2023, at 8:27 a.m., CNS-B stated medications should be administered to residents and then document on the MAR the medications were taken. The licensee's Documentation of Medication Services on the MAR dated October 2014, indicated to document the medication reminder or administration, staff should initial the appropriate box on the MAR form to document the medication has been administered at the appropriate time and date. In addition, any medications held, staff should circle their initials and write a capital H in the same box on the MAR form. Include any notes regarding follow up with the nurse on the back of the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
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	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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 45 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 treatment or therapies were administered as directed, failed to document the reason they were not administered, and any follow up procedures provided to meet the resident's needs for one of one resident (R4) with blood glucose monitoring managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on August 14, 2023, at 9:33 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatments and therapy to residents at the facility. R4's diagnoses included diabetes, asthma, and hyperlipidemia (elevated fat particles in blood). R4's service plan dated December 22, 2021, indicated the resident blood glucose monitoring four times per day. R4's prescriber orders dated May 5, 2023, included an order for blood glucose monitoring to be completed four times per day, and an order for	01960		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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 46 insulin aspart 100 units/milliliter (mL) inject 2 units subcutaneously for blood sugars greater than 400 before meals and bedtime. Report blood sugar to nurse. R4's record contained parameters of unlicensed personnel (ULP) to notify the registered nurse (RN) of R4's blood sugars less than 70 and greater than 400. On August 15, 2023, at 7:58 a.m., ULP-D was observed using appropriate technique to conduct a blood glucose check for R4, which resulted in a reading of 345 milligrams (mg)/deciliter (dL). After reviewing R4's medication administration record (MAR), ULP-D stated R4 would not be receiving any insulin aspart as R4's reading was less than 400. R4's Blood Glucose Record dated July 1, 2023, through August 15, 2023, indicated blood glucose levels were to be completed four times a day. The following dates resulted in a blood glucose not recorded, level under 70, and level over 400: -July 9, 2023, before supper, blood glucose was 526; -July 9, 2023, before bed, blood glucose was 408; -July 11, 2023, before breakfast, blood glucose was 59; -July 12, 2023, before supper and bed, there were no blood glucose readings recorded; -July 15, 2023, before breakfast, blood glucose was 62; -July 15, 2023, before supper, blood glucose was 412; -July 16, 2023, before breakfast, blood glucose was 61; -July 20, 2023, before breakfast, blood glucose was 69; -July 22, 2023, before breakfast, blood glucose	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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 was 63; -July 25, 2023, before breakfast, blood glucose was 55; -July 25, 2023, before supper, blood glucose was 427; -July 26, 2023, before lunch, blood glucose was 428; -July 28, 2023, before supper, blood glucose was 417; -July 30, 2023, before bed, blood glucose was 454; -August 1, 2023, before breakfast, blood glucose was 69; -August 4, 2023, before breakfast, blood glucose was 60; -August 6, 2023, before breakfast, blood glucose was 52; and -August 6, 2023, before bed, blood glucose was 411. R4's record lacked evidence the RN was notified of the above noted blood glucose results, which were not recorded, less than 70 mg/dL, and greater than 400 mg/dL as ordered by the prescriber. On August 16, 2023, at 10:34 a.m., CNS-B stated ULP's should notify the RN for readings that were outside of R4's blood glucose parameters by submitting a communication note to the RN and a follow up note would have been completed by the RN, however, the above blood glucose readings outside of R4's normal range were not reported to the RN. The licensee's Individualized Medication, Treatment and Therapy Management Plans policy dated September 1, 2016, indicated resident-specific requirements relating to documentation of treatment received, verification	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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 48 that all treatment was administered as prescribed, and monitoring of treatment to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
02310 SS=D	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 ensure safe oxygen storage, according to acceptable health care, medical, or nursing standards for one of one resident (R6). 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:	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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 49 R6's diagnoses included pulmonary emphysema (chronic lung condition) and legally blind. R6's record indicated R6 used oxygen at four (4) liters per minute (LPM) via nasal cannula with activity as needed. On August 14, 2023, at 1:36 p.m., the surveyor and unlicensed personnel (ULP)-C observed 16 oxygen cylinders secured and four (4) small oxygen cylinders standing unsecured, and one (1) oxygen cylinder laying on its side unsecured by living room wall in R6's apartment. ULP-C stated all the cylinders should be secured. On August 14, 2023, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated all oxygen cylinders should be secured. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			
03000 SS=E	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a	03000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
03000	Continued From page 50 vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative	03000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
03000	Continued From page 51 agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) an unwitnessed fall with injury for three of three residents (R7, R8, R9). 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: R7 R7's diagnoses included hypertension (HTN-high blood pressure), amputation at left midfoot, gait disturbance (unsteady balance), and anxiety. R7's service plan dated May 27, 2023, indicated R7 received assistance with medication reminders, bathing, toileting, and escorts. R7's record contained the following falls reports: -March 9, 2023, at 10:50 a.m., R7 had an unwitnessed fall and was found on floor by unidentified staff. Unidentified staff indicated R7	03000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
03000	Continued From page 52 lost balance. R7 had lump on back of head/ice applied to area. Primary physician was updated via fax. -April 3, 2023, at 11:30 p.m., R7 had an unwitnessed fall and was found on floor by an unidentified staff. Unidentified staff indicated R7 lost balance on a wet bathroom floor and R7 landed on bottom. Primary physician was updated via fax. -April 8, 2023, at 3:15 p.m., R7 had an unwitnessed fall and was found on floor in the licensee's community dining room by an unidentified staff. Unidentified staff indicated R7 hit her head and a hematoma (bruise)/small [sic] to back of head. Primary physician was updated via fax. -April 12, 2023, at 5:15 a.m., R7 had an unwitnessed fall and was found on floor by unidentified staff. Unidentified staff indicated R7 lost balance and fell to the floor. R7 injuries included R7 hit back of head and abrasion on R7's back between the shoulder blades. Primary physician was updated via fax. -April 27, 2023, at 3:05 a.m., R7 was found on floor by unidentified staff. Unidentified staff indicated R7 slid out of left chair attempting to stand to get to the bathroom. No injury occurred. -April 27, 2023, at 3:15 a.m., R7 had a witnessed fall by unidentified staff. R7 lost balance while walking with walker. R7 had a chin laceration, right bridge of nose laceration, right eyebrow laceration, mouth trauma, teeth knocked out, and left elbow and ear skin tears. Unidentified staff applied pressure to face lacerations. Resident was seen and evaluated in ED (emergency department). -May 1, 2023, at 6:45 p.m., R7 had an unwitnessed fall. R7 pushed alarm, unidentified staff found R7 on kitchen floor, on her back with walker tipped over to the side. R7 stated "I may	03000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
03000	Continued From page 53 be bumped my head." Contributing factors included impaired balance and impaired judgement. Injury occurred on right forearm skin tear. Cleansed skin tear with soap and water, applying steri stirps, gauze and tegaderm. Primary physician was updated via fax. R8 R8's diagnoses included back pain, hypothyroidism (underactive thyroid), and depression with anxiety. R8's service plan dated, June 10, 2023, indicated R8 received assistance with medication set-ups, medication reminders and bathing. R8's record contained the following fall report: -April 13, 2023, at 6:20 a.m., R8 had an unwitnessed fall and was found on the floor by unidentified staff. R8 did not know what happened. R8 had injury to right hip and was sent to the ED. Primary physician was updated via fax. R8's record contained the following progress note: -April 13, 2023, at 3:20 p.m., progress note by registered nurse (RN)-BB noted "returned from ED with no findings related to injury from fall. White blood cells was increased and started on an antibiotic therapy. Is weak, confused, and requires increased assistance, daughter present." R9 R9's diagnoses included kidney cancer, osteoarthritis (breakdown of cartilage in joints), and gastroesophageal reflux disease (acid reflux). R9's service plan dated, March 11, 2023, indicated R9 received assistance with medication	03000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537		
(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
03000	Continued From page 54 set-ups, medication reminders, bathing, and morning and evening cares. R9's record contained the following fall report: -March 24, 2023, at 7:50 p.m., R9 had an unwitnessed fall and was found by unidentified staff in her apartment on the floor in sitting position with walker tipped over to the left of her. R9 has left cheekbone and facial swelling, and left knee pain with swelling. Report did not indicate if resident knew how she fell. Nurse and family was notified. Ice pack was placed on facial swelling and was sent to ED. Primary physician was updated via fax. R9's record contained the following progress note: -March 25, 2023, at 9:30 a.m., RN-BB noted "post fall/ED return, left eye hematoma, mild swelling. Left knee is swollen with minimal abrasions and are stable. Has been taking as needed (PRN) Tylenol. Stiff and sore, favoring left leg, unsteady gait, assist with mobility, daughter present." On August 16, 2023, at 10:38 a.m., clinical nurse supervisor (CNS)-B stated a reportable MAARC report would include abuse, elopement, and unexplained injuries. CNS-B stated no MAARC reports were made for the above noted unwitnessed falls with injury since the residents were able to explain how each fall occurred. CNS-B further stated all MAARC reports should be reported immediately or within 24 hours. The licensee's Vulnerable Adult policy dated July 1993, indicated mandated reports include unexplained injuries. No further information was provided.	03000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30317	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2023
NAME OF PROVIDER OR SUPPLIER MILL STREET RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 802 SOUTH MILL STREET FERGUS FALLS, MN 56537			
(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
03000	Continued From page 55 TIME PERIOD FOR CORRECTION: Seven (7) days	03000			



MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: 08/14/23
Time: 13:01:54
Report: 7935231194

Food and Beverage Establishment Inspection Report

Page 1

Location:

Mill Street Residence
802 South Mill Street
Fergus Falls, MN56537
Otter Tail County, 56

Establishment Info:

ID #: 0037987
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2187392900
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.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
APRIL EMERY AND CHERI NETTLETON HAVE TAKEN SERVSAFE. JUST NEED TO SUBMIT APPLICATION FOR STATE CERTIFICATION. CLANCY IS ALSO GOING TO GET CERTIFIED. APPLICATION EMAILED TO CLANCY.

Comply By: 09/30/23

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

NO HAND WASHING POSTER AT DISH ROOM HAND SINK. THERE WERE 2 AT COOKLINE HAND SINK, SO 1 MOVED TO DISH ROOM.

Corrected on Site

Surface and Equipment Sanitizers

Hot Water: = at 171 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Three Comp Sink
Violation Issued: No

Type: Full
Date: 08/14/23
Time: 13:01:54
Report: 7935231194
Mill Street Residence

Food and Beverage Establishment Inspection Report

Page 2

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Sanitizing Bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: Walk In
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Upright Cooler
Violation Issued: No

Process/Item: Cooking
Temperature: 194 Degrees Fahrenheit - Location: Corn Beef
Violation Issued: No

Process/Item: Hot Holding
Temperature: 160 Degrees Fahrenheit - Location: Tomato Soup
Violation Issued: No

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

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

I acknowledge receipt of the MN Department of Health inspection report number 7935231194 of 08/14/23.

Certified Food Protection Manager: Application Emailed

Certification Number: _____ Expires: ____/____/____

Signed: _____

Clancy
cgmaihori@lrhc.org

Signed: 7935

7935

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