DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 27, 2023

Licensee
Traditions Of Owatonna II LLC
150 24th Street Northeast
Owatonna, MN 55060

RE: Project Number(s) SL30580015

Dear Licensee:

On February 7, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the November 9, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

HHH

Electronically Delivered

December 9, 2022

Administrator
Traditions Of Owatonna II, LLC
150 24th Street Northeast
Owatonna, MN 55060

RE: Project Number(s) SL30580015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 9, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000

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

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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

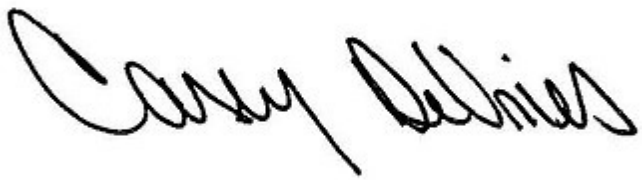
REQUESTING A HEARING

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

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

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

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30580	A. BUILDING: _____ B. WING _____	11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF OWATONNA II LLC	150 24TH STREET NE OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30580015-0 On November 7, 2022, through November 9, 2022, the Minnesota Department of Health conducted a survey at the above provider and the following correction orders are issued. At the time of the survey, there were 38 residents, all of whom received services under the provider's Assisted Living with Dementia-Care license. An immediate correction order was identified on November 9, 2022, issued for SL30580015-0, tag identification 2310. On November 9, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, isolated scope violation.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: 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 November 8, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to review its emergency preparedness plan, or practice and document testing of its plan at least twice annually as required. In addition, the facility failed to evaluate/revise its missing person policy at least quarterly or post its emergency plan or exit diagrams in the building. This had the potential to	0 680		

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0 680	Continued From page 3 affect all 38 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: During the entrance conference on November 7, 2022, at 11:55 a.m., the surveyor requested to view the facility's emergency plan and related documentation, which was later provided. EMERGENCY PLAN TESTING AND DOCUMENTATION The surveyor reviewed the facility's emergency preparedness (EP) plan, dated August 2021, and accompanying documents. There lacked a documented training and testing plan and evidence the facility tested its EP plan or conducted and/or participated in any tabletop exercise to test its plan and document the results of testing at least twice annually as required. Additionally, there was no evidence the EP plan was reviewed since its effective date, August 2021, or at least annually as required. Page 10 of the section titled "Executive Summary" contained the statement "This serves as documentation that this plan has been reviewed and approved." Below the declaration was space for signatures and dates to signify review of the plan; the form was unsigned and undated.	0 680		

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0 680	Continued From page 4 On November 9, 2022, at 3:00 p.m., senior regional director (SRD)-A stated they had no evidence of implementation or testing of the plan. SRD-A said due to the lack of on-site leadership, requirements were not met. REVIEW OF MISSING PERSON POLICY The surveyor reviewed the facility's Missing Resident (Elopement) policy, effective August 2021, which was included in the EP plan. There was no evidence the facility reviewed or updated the policy at least quarterly as required. On November 9, 2022, at 3:05 p.m., SRD-A said she did not see any revision of the policy or know it had been reviewed by the assisted living director and the site nurse. SRD-A stated she was not familiar with the requirement to review the plan, adding the site did not have continual leadership. LACK OF EMERGENCY PLAN AND EXIT DIAGRAMS Following the entrance conference on November 7, 2022, at 1:17 p.m., the surveyors toured the facility with community relations coordinator (CRC)-N. During the tour, the surveyors found no information about the licensee's EP plan, facility floor plans, or emergency exit diagrams posted or otherwise displayed emergency information in the facility hallways, doorways, or common areas. On November 9, 2022, at 2:56 p.m., SRD-A stated they did not know why the emergency plan and exit diagrams were not posted in the building. No further information was provided.	0 680		

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0 680	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (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		

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0 810	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the required posted fire evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On November 08 2022, from approximately 12:00 PM to 2:00 PM, survey staff requested fire safety training and evacuation plan documentation, but the licensee did not have the evacuation posted at the time of request. (HM)-A verbally confirmed survey staff observation during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not	0 970		

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0 970	Continued From page 7	0 970		

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 for three of three residents (R1, R4, R5).

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

The findings include:

R1
R1 was admitted for services on June 7, 2022. R1's record contained a Resident Agreement, signed by R1 on June 7, 2022.

R4
R4 was admitted for services on August 24, 2022. R4's record contained a Resident Agreement, signed by R4's designated representative August 24, 2022.

R5
R5 was admitted for services June 9, 2021. R5's

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0 970	Continued From page 8	0 970		

record contained a Resident Agreement, signed by R5's designated representative dated August 1, 2021.

R1, R4 and R5's assisted living contracts included three clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. The facility's contract contained the following:

Section 30 of the contract, titled "Personal Property" indicated: Resident agrees that the Community is not responsible for any loss or damage to Resident's personal property due to any reason or cause, including theft, other than the Community's own negligence. Resident further agrees that Community is not responsible for damage to Resident's personal property due to fire, water, tornado or other acts of nature and events beyond the Community's control.

Section 33 of the contract titled "Indemnification" indicated: As a resident of the Community, Resident assumes the risk for Resident's own safety and for the safety of Resident's guests and agents. Resident will indemnify and hold harmless the Community, its employees, officer, manager, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to proper, arising from or out of the use by Resident of the rented premises or any other part of the Community's property, or caused wholly or in part by an act or omission of Resident or resident's guests or agents.

Section 34 of the contract titled "Liability" indicated: The Community is not liable to Resident or Resident's guests for any injury,

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0 970	Continued From page 9 death or property damage occurring in the Apartment or on the Community's premises unless such injury, death or property damage occurs as the result of Community's own negligent acts or those of its employees, officers, managers, owners or agents. The Community Is also not liable for any Injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third-party providers. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold the Community harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment or on the Community's premises. On November 9, 2022, at 8:02 a.m., regional registered nurse (RN)-D stated she was aware the indemnification clause in the contract needed to be removed, and the new contract dated September 2022 reflected that change, however, any residents admitted prior to that date had the old contract, and the licensee had not provided a modification to those residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.	01060		

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01060	Continued From page 10 (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation to	01060		

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01060	Continued From page 11	01060		

one of two residents (R2). In addition, the licensee failed to notify the Office of Ombudsman for Long-Term Care of R2's relocation within four days as required.

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:

R2 was admitted to the facility on June 29, 2022, with diagnoses including Alzheimer's dementia, atrial fibrillation, cardiomegaly (enlarged heart), and osteoarthritis.

R2's discharge summary dated July 27, 2022, identified the licensee discharged R2 to a higher level of care.

R2's progress notes dated July 6, 2022, included the following:
-11:03 a.m., "Increased paranoia and wandering. Attempted to run over staffs [sic] foot with wheelchair then kicked staffs [sic] ankle who is wearing a brace due to injury. Attempted to tip wheelchair over while in it. Instructed staff to give PRN [as needed] Seroquel [used to treat certain mental/mood disorders]. Refusing to take med. Crushed med and put in drink. Refusing to drink it. Moving things out of room into hallway. Updated PCP [primary care physician] on behaviors."
-1:03 p.m., "Staff noted resident to have

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increased agitation towards staff between 1000 - 1303 [10:00 a.m. to 1:03 p.m.] today. Staff attempted to administer PRN Seroquel x2 [two times] and resident kicked staff's already injured foot. Resident cornered staff while in wheelchair and began banging staff against wall x2. Resident ripped towel rack off the bathroom wall. Staff attempted to take rack from resident and resident swatted staff's left arm with towel rack x2. Staff was then able to take the rack away from resident. Writer updated DON [director of nursing]. DON instructed writer to send resident to ER [emergency room] for psych [psychiatric] evaluation. Writer called 911. EMTs [emergency medical technician] and police arrived to community and transferred resident to ER. Updated POA [power of attorney] and PCP."

R2's record lacked evidence the licensee delivered the required notice as soon as practicable to the resident, legal representative, and designated representative or to the Office of Ombudsman for Long-Term Care to indicate the resident was relocated and had not returned to the facility within four days. The licensee failed to provide R2 and R2's representative a written notice that contained, at a minimum:
-the reason for the relocation;
-the name and contact information for the location to which the resident has been relocated and any new service provider;
-contact information for the Office of Ombudsman for Long-Term Care;
-if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and
-a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section

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01060	Continued From page 13 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On November 8. 2022, at 9:20 a.m., regional registered nurse (RN)-D stated the required written notice had not been completed and written notice was not provided to the resident, legal representative, or designated representative. RN-D also said the Office of Ombudsman for Long-Term Care was not given notice when the resident was relocated and had not returned to the facility within four days. The licensee's 1.07 Emergency Relocation policy, dated August 1, 2021, indicated the licensee may remove a resident from the facility in an emergency due to resident's urgent medical needs and that an emergency relocation is not a termination. The policy indicated the facility would provide written notice as soon as practicable to the resident, resident's representative and designated representative that would include the content identified above. The policy also indicated the office of Ombudsman would be notified if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01070 SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been	01070		

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01070	Continued From page 14 effectuated. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written termination of housing and did not allow a resident to return to the facility after an emergency relocation when one of one resident (R2) posed an imminent safety risk to herself, other residents, and facility staff members and required hospitalization. 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: R2 was admitted to the facility on June 29, 2022, with diagnoses including Alzheimer's dementia, atrial fibrillation, cardiomegaly (enlarged heart), and osteoarthritis. R2's progress notes included the following: July 6, 2022 -11:03 a.m., "Increased paranoia and wandering. Attempted to run over staffs [sic] foot with wheelchair then kicked staffs [sic] ankle who is wearing a brace due to injury. Attempted to tip wheelchair over while in it. Instructed staff to give PRN [as needed] Seroquel [used to treat certain mental/mood disorders]. Refusing to take med. Crushed med and put in drink. Refusing to drink it. Moving things out of room into hallway.	01070		

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01070	Continued From page 15 Updated PCP [primary care physician] on behaviors." -1:03 p.m., "Staff noted resident to have increased agitation towards staff between 1000 - 1303 [10:00 a.m. to 1:03 p.m.] today. Staff attempted to administer PRN Seroquel x2 [two times] and resident kicked staff's already injured foot. Resident cornered staff while in wheelchair and began banging staff against wall x2. Resident ripped towel rack off the bathroom wall. Staff attempted to take rack from resident and resident swatted staff's left arm with towel rack x2. Staff was then able to take the rack away from resident. Writer updated DON [director of nursing]. DON instructed writer to send resident to ER [emergency room] for psych [psychiatric] evaluation. Writer called 911. EMTs [emergency medical technician] and police arrived to community and transferred resident to ER. Updated POA [power of attorney] and PCP." -5:03 p.m., "Writer spoke with mental health case worker in regards to behaviors in community, advised Resident is unable to return to community until stable on psych meds and re-assessment is completed. July 7, 2022, 11:00 a.m., "Resident hospitalized at this time until medications management can be proven to negate behaviors that are dangerous to herself and others." July 13, 2022, 3:57 p.m., the licensee was informed R2 was transferred to another hospital. July 27, 2022, 10:33 a.m., "Received update from United in St Paul, Resident had a fall there and broke her hip. She will be requiring a SNF upon discharge per MD. Notified PCP, discontinued medications and stopped service plan and tasks."	01070		

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01070	Continued From page 16 On November 8. 2022, at 9:20 a.m., regional registered nurse (RN)-D stated some of the above progress notes were entered by the previous health care coordinator/RN was to contact her if there were any concerns regarding the return of a resident. The licensee's 1.13 Resident Right to Return policy dated August 1, 2021, indicated if a resident is absent from [the facility] for any reason, including an emergency relocation, the facility will not refuse to allow a resident to return if a termination of housing has not been effectuated. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01070		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing	01440		

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01440	Continued From page 17 delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) directly supervised unlicensed personnel (ULP) performing delegated tasks within 30 days of the staff performing such tasks for one of two employees (ULP-H). 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 November 7, 2022, at 11:53 a.m., registered nurse (RN)-B stated the facility has unlicensed staff perform delegated tasks, including medication administration and were supervised by a registered nurse. ULP-H was hired on September 25, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021.	01440		

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01440	Continued From page 18 On November 8, 2022, between approximately 6:40 a.m. and 8:30 a.m., the surveyor observed ULP-H assist with compression stockings, perform catheter cares, and administer medications to several residents on the locked dementia unit. ULP-H's employee record lacked documentation the RN supervised ULP-H within 30 days after performing delegated tasks. On November 9, 2022, at 11:58 a.m., regional registered nurse (RN)-D said the supervision and observation of ULP-H would have been the responsibility of the RN who left the facility about a month ago. After unsuccessfully searching for documentation, RN-D said there "should have been" a 30-day supervisory visit for ULP-H. The licensee's 6.12 Supervision of Staff - Delegated Services policy, dated August 1, 2021, indicated staff who provide delegated nursing or therapy tasks to residents will be supervised by an RN or appropriate licensed health professional to verify that work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. The policy indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after which the individual begins working and first performs the delegated tasks for residents. The policy also indicated documentation of supervision activities will be retained in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		

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01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01470		

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01470	Continued From page 20 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of three employees (unlicensed personnel (ULP)-F and ULP-H) received orientation to assisted living facility licensing requirements and regulations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-F	01470		

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01470	Continued From page 21 ULP-F began providing assisted living with dementia care services for the licensee on August 1, 2021. ULP-F's training records lacked evidence to indicate the employee had received orientation to include the following topics: -an overview of chapter 144G; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On November 9, 2022, at 10:42 a.m., regional	01470		

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registered nurse (RN)-D stated the required orientation to assisted living had been assigned to ULP-F online, however, ULP-F had not completed the assigned orientation.

ULP-H

ULP-H was hired on September 25, 2019, under the comprehensive home care license and began providing assisted living with dementia care services on August 1, 2021.

On November 8, 2022, between approximately 6:40 a.m. and 8:30 a.m., the surveyor observed ULP-H assist with compression stockings, perform catheter cares, and administer medications to several residents in the locked dementia unit.

ULP-H's training records lacked evidence to indicate the employee had received orientation to assisted living requirements and included following topics:
-an overview of chapter 144G (statutes);
-the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;
-a review of the types of assisted living services the employee will be providing and the facility's category of licensure.

On November 9, 2022, at 11:46 a.m. RN-D said training for assisted living at the time of the new license was assigned to staff to complete, that staff had a "decent timeframe" and deadline to complete the training. Although RN-D could not recall when the training was assigned, RN-D said this should have been completed.

The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2021, identified all staff providing and supervising

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01470	Continued From page 23 direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. The policy indicated orientation included the topics identified above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with	01500		

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TRADITIONS OF OWATONNA II LLC	150 24TH STREET NE OWATONNA, MN 55060

(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
01500	Continued From page 24 residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training was completed and included all required topics for two of three employees (unlicensed personnel (ULP)-F and ULP-H). This practice resulted in a level two violation (a	01500		

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01500	Continued From page 25 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-F was hired January 9, 2009, and began providing assisted living services on August 1, 2021. ULP-F's employee training records lacked evidence ULP-F had completed any training in the last 12 months. ULP-F's record lacked evidence annual training had been completed as required in the following areas: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's	01500		

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01500	Continued From page 26	01500		

disease, or related disorders;
-review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and
-the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.
ULP-H
ULP-H was hired September 25, 2019, and began providing assisted living services on August 1, 2021.

On November 8, 2022, at 6:50 a.m., the surveyor observed ULP-H put on a resident's compression stockings, then later complete an hourly check of residents in their rooms.

ULP-H's training transcript from September 2021 through November 2022, indicated ULP-H completed 5.5 hours of required 8 hours annual training for each 12 months of employment. ULP-H's training lacked required content to include:
-reporting of maltreatment of vulnerable adults or minors;
-assisted living bill of rights; and
-review of provider's policies and procedures.

On November 9, 2022, at 10:42 a.m., regional registered nurse (RN)-D stated annual training was assigned through an online program; however, ULP-F and ULP-H had not completed the assigned annual training. RN-D did not know why staff training was not completed, as staff were assigned training and had a "decent timeframe" to complete it.

The licensee's 5.04 Annual Required Staff Training policy, dated August 1, 2021, included all

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01500	Continued From page 27 staff that perform direct care services will complete at least eight (8) hours of annual training for each 12 months of employment. The policy listed required training topics to be completed and included the items identified above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received the required amount of dementia care training in the	01540		

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required time frame for two of three employees (registered nurse (RN)-B and unlicensed personnel (ULP)-F).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

During the entrance conference on November 7, 2022, at 11:45 a.m., senior regional director (SRD)-A stated they were licensed as assisted living facility with dementia care.

RN-B
RN-B was hired August 13, 2022, full-time, to provide direct care to the residents and supervise staff.

RN-B's employee record indicated the employee completed 5.75 of the 8 required hours of dementia training within 120 hours of RN-B's start date.
ULP-F
ULP-F was hired January 9, 2009, and began providing services on August 1, 2021, under the facility's assisted living with dementia care license.

ULP-F's training records indicated the employee completed zero of the annually-required 2 hours dementia education during the last year.

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01540	Continued From page 29 On November 9, 2022, at 4:15 p.m., assistant manager (AM)-O stated they required staff to complete at least the state minimum requirements for dementia training, for both floor or direct-care staff and this would also apply to the licensed nurses as well. AM-O said RN-B should have completed the dementia requirement. AM-O said things were "falling through the cracks" because there was a lack of supervisors in the building, but added that was no excuse for staff not having required training completed. The licensee's 5.03 Dementia Training policy dated August 1, 2021, identified all staff are required to complete dementia training at the time of hire and annually thereafter. The policy indicated for assisted living with dementia care facilities, supervisors of direct care staff will complete eight (8) hours of initial training within 120 hours of the employment start date and direct care employees will complete eight (8) hours of initial training within 80 hours of the employment start date. Further, the policy directed all staff will complete two (2) hours of additional training for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=E	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	01620		

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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 facility failed to ensure the registered nurse (RN) completed a change of condition assessment for one of four residents (R8).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:

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01620	Continued From page 31 On November 8, 2022, at 7:28 a.m., the surveyor observed unlicensed personnel (ULP)-F change R8's indwelling urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag) bed drainage bag to a leg drainage bag and provide catheter and perineal care. R8's diagnoses included congestive heart failure, benign prostatic hyperplasia, atrial fibrillation, and arthritis. R8's care plan (identified as the service plan) dated December 7, 2020, identified bladder/bowel as a problem with the following interventions: -assistance needed to use toilet and maintain bladder continence; -bladder incontinence care needs to be provided; -is continent of bowels; -report to nurse changes in bladder continence; -report to the nurse any changes in bowel continence; and -uses incontinence products (pull-up, liner, brief). R8's care plan failed to identify R8 had an indwelling urinary catheter. R8's comprehensive assessment dated September 2, 2022, indicated R8's care plan, signed December 7, 2020, by RN-D, had been reviewed and toileting needs were appropriate. R8's comprehensive assessment failed to identify the resident had an indwelling urinary catheter or that R8 needed assistance with it. R8's record included document titled "Evaluation and Management" which indicated R8 was seen by a nurse practitioner on September 15, 2022, and was identified by RN-D as a face-to-face visit. The document indicated R8 was seen as follow-up for a September 4, 2022, emergency room visit where the resident presented with	01620		

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abdominal pain and inability to urinate, at which time, an indwelling urinary catheter was placed. The document indicated R8 was feeling better and was not having any difficulties with the catheter.
It further identified the following assessment and plan related to the retention of urine:
-SN [skilled nursing] to evaluate and treat for ongoing catheter cares;
-unable to do a voiding trial r/t AL [related to assisted living] setting and no on-site catheter cares;
-SN to come and set up schedule for voiding trial - will need to remove by LPN [licensed practical nurse] the morning of SN visit and if no void by time of visit, catheter to be replaced; and
-if voiding trial fails, consider urology follow up.

A signed prescriber's order dated October 11, 2022, directed to DC [discontinue] order for voiding trial - patient [R8] wishes to keep catheter in until urology can make recommendations. Please have skilled nursing come and change catheter as soon as possible."

On November 8, 2022, at 3:30 p.m., RN-D stated there was no comprehensive assessment, updated service/care plan, or a treatment plan completed upon initiation of the indwelling urinary catheter for R8. RN-D said the catheter was not addressed on the assessment or care plan and although staff had been trained and competency tested on catheter cares, they had not been delegated to perform them for R8. RN-D also said staff had not documented they completed the catheter cares.

On November 9, 2022, at 4:44 p.m., RN-D stated the first notation in R8's chart regarding the catheter was the face-to-face visit with the

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01620	Continued From page 33 medical doctor on September 15, 2022. RN-D said at that time, they should have completed a change in condition assessment and updated the service and treatment plans. RN-D said there should have been tasks on the treatment administration record for the catheter cares. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, identified on-going 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan.	01640		

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01640	Continued From page 34 (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of four resident (R8) service plans was revised to reflect the current services provided. 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). Then findings include: R8's diagnoses included congestive heart failure, benign prostatic hyperplasia, atrial fibrillation, and arthritis. R8's care plan (identified as the service plan) dated December 7, 2020, identified bladder/bowel as a problem with the following interventions: Assistance needed to use toilet and maintain bladder continence; bladder incontinence care needs to be provided; report to nurse changes in bladder continence; uses incontinence products (pull-up, liner, brief) and supply; disposal managed by resident/family/staff and dispose of used incontinent products every shift.	01640		

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01640	Continued From page 35 On November 8, 2022, at 7:28 a.m., the surveyor observed unlicensed personnel (ULP)-F change R8's indwelling urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag) bed drainage bag to a leg drainage bag and provide catheter and perineal care. R8's comprehensive assessment dated September 2, 2022, indicated R8's care plan, signed December 7, 2020, by RN-D, had been reviewed and his toileting needs were appropriate. R8's comprehensive assessment failed to identify that he had an indwelling urinary catheter or that he needed assistance with it. R8's record included document titled "Evaluation and Management", which indicated R8 was seen by a nurse practitioner on September 15, 2022, and was identified by regional registered nurse (RN)-D to be a face-to-face visit. The document identified that R8 was seen as a follow up for an emergency room visit on September 4, 2022, where he presented with abdominal pain and inability to urinate, at which time, an indwelling urinary catheter was placed. On September 15, 2022, R8 was feeling better and was not having any difficulties with the catheter. It further identified the following assessment and plan related to the retention of urine: -SN [skilled nursing] eval and treat for ongoing catheter cares; -unable to do a voiding trial r/t AL [related to assisted living] setting and no on-site catheter cares; -SN to come and set up schedule for voiding trial - will need to remove by LPN [licensed practical nurse] the morning of SN visit and if no void by time of visit, catheter to be replaced; and -if voiding trial fails, consider urology follow up.	01640		

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01640	Continued From page 36 A prescriber's order on October 11, 2022, signed by a nurse practitioner, identified "DC [discontinue] order for voiding trial - patient wishes to keep catheter in until urology can make recommendations. Please have skilled nursing come and change catheter as soon as possible." R8's care plan, identified by RN-D as the service plan, failed to identify R8 had an indwelling urinary catheter and lacked evidence of a current individualized treatment and therapy management record, for urinary catheter cares, which contained at least the following: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On November 8, 2022, at 3:30 p.m., RN-D stated there was no updated service/care plan, or a treatment plan completed upon initiation of the indwelling urinary catheter. It was not addressed on the assessment or care plan. Although staff had been trained and competency tested on catheter cares, they had not been delegated to perform them for R8, and staff had not	01640		

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01640	Continued From page 37 documented that they completed the catheter cares. On November 9, 2022, at 4:44 p.m., RN-D stated the first notation in R8's chart regarding the catheter was a face-to-face visit with the medical provider on September 15, 2022. RN-D stated at that time, they should have completed a change in condition assessment and updated the service and treatment plans. RN-D said there should have been tasks on the treatment administration record for the catheter cares. The licensee's 7.03 Treatment & Therapy Management Plan policy dated August 1, 2021, identified the following: "1. [the licensee] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident-specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions. 2. The treatment or therapy management record	01640		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF OWATONNA II LLC	150 24TH STREET NE OWATONNA, MN 55060

(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
01640	Continued From page 38 must be current and updated when there are any changes." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure mediations were administered as prescribed for one of three residents (R3) observed during medication administration. 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	01760		

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01760	Continued From page 39	01760		

residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

R3's service plan dated April 28, 2022, indicated R3 received medication management services, including medication administration.

On November 8, 2022, at 7:07 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R3, which included gabapentin (a medication prescribed for pain) 100 mg (milligrams).

R3's prescriber's orders, signed May 18, 2022, included gabapentin capsule 100 mg and directed to give 100 mg by mouth one time a day for pain. After the typed order there was a handwritten notation of "at bedtime."

R3's medication administration records for October 2022 and November 2022 indicated R3 had received Gabapentin Capsule 100 mg every day at 8:00 a.m.

On November 9, 2022, at 10:42 a.m., regional registered nurse (RN)-D stated the RN who transcribed the order must have missed that the physician wrote "at bedtime" on the physician's orders dated May 18, 2022. RN-D said the gabapentin for R3 should have been administered at bedtime as ordered.

The licensee's 7.13 Medication & Treatment Orders - Implementing policy dated August 1, 2021, identified upon receipt of a medication and/or treatment order, whether new or change of an order from an authorized prescriber, a

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01760	Continued From page 40 licensed nurse must take action to implement the order within 24 hours. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must	01940		

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01940	Continued From page 41 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R8) who had an indwelling urinary catheter. 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). Then findings include: R8's diagnoses included congestive heart failure, benign prostatic hyperplasia, atrial fibrillation, and arthritis. R8's care plan (identified as the service plan) dated December 7, 2020, identified bladder/bowel as a problem with the following interventions: Assistance needed to use toilet and maintain bladder continence; bladder incontinence care needs to be provided; report to nurse changes in bladder continence; uses incontinence products (pull-up, liner, brief) and supply; disposal managed by resident/family/staff and dispose of used incontinent products every shift. On November 8, 2022, at 7:28 a.m., the surveyor observed unlicensed personnel (ULP)-F change	01940		

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01940	Continued From page 42 R8's indwelling urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag) bed drainage bag to a leg drainage bag and provide catheter and perineal care. R8's comprehensive assessment dated September 2, 2022, indicated R3's care plan, signed December 7, 2020, by registered nurse (RN)-D, had been reviewed and his toileting needs were appropriate. R8's comprehensive assessment failed to identify that he had an indwelling urinary catheter or that he needed assistance with it. R8's record included document titled "Evaluation and Management", which indicated R8 was seen by a nurse practitioner on September 15, 2022, and was identified by RN-D to be a face-to-face visit. The document identified that R8 was seen as a follow up for an emergency room visit on September 4, 2022, where he presented with abdominal pain and inability to urinate, at which time, an indwelling urinary catheter was placed. On September 15, 2022, R8 was feeling better and was not having any difficulties with the catheter. It further identified the following assessment and plan related to the retention of urine: -SN [skilled nursing] eval and treat for ongoing catheter cares; -unable to do a voiding trial r/t AL [related to assisted living] setting and no on-site catheter cares; -SN to come and set up schedule for voiding trial - will need to remove by LPN [licensed practical nurse] the morning of SN visit and if no void by time of visit, catheter to be replaced; and -if voiding trial fails, consider urology follow up. A prescriber's order on October 11, 2022, signed	01940		

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01940	Continued From page 43	01940		

by a nurse practitioner, identified "DC [discontinue] order for voiding trial - patient wishes to keep catheter in until urology can make recommendations. Please have skilled nursing come and change catheter as soon as possible."

R8's care plan failed to identify R8 had an indwelling urinary catheter and lacked evidence of a current individualized treatment and therapy management record, for urinary catheter cares, which contained at least the following:
-a statement of the type of services that will be provided;
-documentation of specific resident instructions relating to the treatments or therapy administration;
-identification of treatment or therapy tasks that will be delegated to unlicensed personnel;
- procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and
-any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.

On November 8, 2022, at 3:30 p.m., RN-D stated there was no comprehensive assessment, updated service/care plan, or a treatment plan completed upon initiation of the indwelling urinary catheter. It was not addressed on the assessment or care plan. Although staff had been trained and competency tested on catheter cares, they had not been delegated to perform them for

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01940	Continued From page 44 R8, and staff had not documented that they completed the catheter cares. On November 9, 2022, at 4:44 p.m., RN-D stated the first notation in R8's chart regarding the catheter was a face-to-face visit with the medical provider on September 15, 2022. RN-D stated at that time, they should have completed a change in condition assessment and updated the service and treatment plans. RN-D said there should have been tasks on the treatment administration record for the catheter cares. The licensee's 7.03 Treatment & Therapy Management Plan policy dated August 1, 2021, identified [the licensee] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain items identified above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health	01950		

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01950	Continued From page 45	01950		

professional has:
(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;
(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and
(3) communicated with the unlicensed personnel about the individual needs of the resident.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident receiving prescribed treatments, and documented those instructions in the resident's record for one of one resident (R8) who had an indwelling urinary catheter.

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).

Then findings include:

R8's diagnoses included congestive heart failure, benign prostatic hyperplasia, atrial fibrillation, and arthritis.

R8's care plan (identified as the service plan) dated December 7, 2020, identified bladder/bowel as a problem with the following interventions:

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01950	Continued From page 46 Assistance needed to use toilet and maintain bladder continence; bladder incontinence care needs to be provided; report to nurse changes in bladder continence; uses incontinence products (pull-up, liner, brief) and supply; disposal managed by resident/family/staff and dispose of used incontinent products every shift. On November 8, 2022, at 7:28 a.m., the surveyor observed unlicensed personnel (ULP)-F change R8's indwelling urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag) bed drainage bag to a leg drainage bag and provide catheter and perineal care. R8's record included document titled "Evaluation and Management" which indicated R8 was seen by a nurse practitioner on September 15, 2022, and was identified by RN-D as a face-to-face visit. The document indicated R8 was seen as follow-up for a September 4, 2022, emergency room visit where the resident presented with abdominal pain and inability to urinate, at which time, an indwelling urinary catheter was placed. The document indicated R8 was feeling better and was not having any difficulties with the catheter. It further identified the following assessment and plan related to the retention of urine: -SN [skilled nursing] to evaluate and treat for ongoing catheter cares; -unable to do a voiding trial r/t AL [related to assisted living] setting and no on-site catheter cares; -SN to come and set up schedule for voiding trial - will need to remove by LPN [licensed practical nurse] the morning of SN visit and if no void by time of visit, catheter to be replaced; and -if voiding trial fails, consider urology follow up.	01950		

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01950	Continued From page 47 A signed prescriber's order dated October 11, 2022, directed to DC [discontinue] order for voiding trial - patient [R8] wishes to keep catheter in until urology can make recommendations. Please have skilled nursing come and change catheter as soon as possible." R8's record lacked documentation regarding R8's indwelling catheter and that the registered nurse: -instructed the ULP in the proper methods with respect to each resident and the ULP demonstrated the ability to competently follow the procedures; -specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and -communicated with the ULP about the individual needs of the resident. On November 8, 2022, at 3:30 p.m., RN-D stated there was no treatment plan completed upon initiation of the indwelling urinary catheter for R8. RN-D said R8's record also lacked "specifics" as to how staff were to care for the catheter. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When	01960		

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01960	Continued From page 48 treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment services were documented in the record for one of one resident (R8) who had an indwelling urinary catheter. 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). Then findings include: R8's diagnoses included congestive heart failure, benign prostatic hyperplasia, atrial fibrillation, and arthritis. R8's care plan (identified as the service plan) dated December 7, 2020, identified bladder/bowel as a problem with the following interventions: Assistance needed to use toilet and maintain bladder continence; bladder incontinence care needs to be provided; report to nurse changes in bladder continence; uses incontinence products (pull-up, liner, brief) and supply; disposal managed by resident/family/staff and dispose of used incontinent products every shift.	01960		

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01960	Continued From page 49 On November 8, 2022, at 7:28 a.m., the surveyor observed unlicensed personnel (ULP)-F change R8's indwelling urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag) bed drainage bag to a leg drainage bag and provide catheter and perineal care. R8's record included document titled "Evaluation and Management" which indicated R8 was seen by a nurse practitioner on September 15, 2022, and was identified by regional registered nurse (RN)-D as a face-to-face visit. The document indicated R8 was seen as follow-up for a September 4, 2022, emergency room visit where the resident presented with abdominal pain and inability to urinate, at which time, an indwelling urinary catheter was placed. The document indicated R8 was feeling better and was not having any difficulties with the catheter. It further identified the following assessment and plan related to the retention of urine: -SN [skilled nursing] to evaluate and treat for ongoing catheter cares; -unable to do a voiding trial r/t AL [related to assisted living] setting and no on-site catheter cares; -SN to come and set up schedule for voiding trial - will need to remove by LPN [licensed practical nurse] the morning of SN visit and if no void by time of visit, catheter to be replaced; and -if voiding trial fails, consider urology follow up. A signed prescriber's order dated October 11, 2022, directed to DC [discontinue] order for voiding trial - patient [R8] wishes to keep catheter in until urology can make recommendations. Please have skilled nursing come and change catheter as soon as possible." R8's record lacked documentation staff were	01960		

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01960	Continued From page 50 completing urinary catheter cares. On November 8, 2022, at 3:30 p.m., RN-D stated there was no treatment plan completed upon initiation of the indwelling urinary catheter for R8, and no documentation staff were providing catheter care. RN-D said there should have been tasks on the treatment administration record for R8's catheter cares. The licensee's 7.03 Treatment & Therapy Management Plan policy dated August 1, 2021, indicated the facility would maintain a current, individualized treatment and therapy management record for each resident, which would include verification that all treatment and therapy was administered as prescribed. The licensee's 2.26 Resident Record - Information and Content policy, dated August 1, 2022, indicated the facility would maintain appropriate and accurate record for each resident receiving assisted living services. The policy indicated the record included documentation that services have been provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's	02110		

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02110	Continued From page 51 values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required policies and procedures for assisted living with dementia care were provided to residents/legal and designated representatives at the time of move-in for three of three residents (R1, R4, R5). This practice resulted in a level one violation (a	02110		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 52 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted for services on June 7, 2022. R4 admitted for services on August 24, 2022. R5 admitted for services on June 9, 2021. R1, R4, and R5's records lacked documentation the residents or residents' representatives received dementia-care policies and procedures required to be provided at the time of move-in. On November 9, 2022, at 7:50 a.m., regional registered nurse (RN)-D stated they were aware of the requirement, but said the residents had not been given the policies. RN-D stated they thought the policies were acknowledged on the service plan document residents signed at admission as part of the agreement, but said the current form did not include the dementia-care policies. RN-D also said every resident had the same contract agreement and therefore none of the residents would have the required dementia policies. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30580	A. BUILDING: _____ B. WING _____	11/09/2022

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TRADITIONS OF OWATONNA II LLC	150 24TH STREET NE OWATONNA, MN 55060

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02310	Continued From page 53	02310		
02310 SS=G	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 the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) with an assistive device (consumer bed rail). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). This practice resulted in an immediate order for correction on November 9, 2022. The findings include: On November 8, 2022, at 3:48 p.m., the surveyor observed an assistive device (Halo Safety Ring) attached to the bed on R1's left side, next to the wall. The device was a metal tube, attached at 90 degrees to the bed frame, with a circle welded to the top of the tube. The circle part of the frame was approximately 12" (inches) in diameter and	02310	On November 9, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, isolated scope violation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30580	A. BUILDING: _____ B. WING _____	11/09/2022

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TRADITIONS OF OWATONNA II LLC	150 24TH STREET NE OWATONNA, MN 55060

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02310	Continued From page 54	02310		

had a metal bar dividing the circle into two parts. The upper part of the circle had metal welded in the space in the shape of a "Y" and the lower part of the circle had three equally spaced bars that were perpendicular to the tube that divided the circle. The bottom of the ring was at the level of the mattress and there was no gap between the device and mattress. R1 told the surveyor she used the rail to reposition when in bed.

R1's diagnoses included rheumatoid arthritis, immunodeficiency, anxiety disorder, obsessive-compulsive disorder, osteoarthritis, and low back pain.

R1's services, identified as the licensee's service plan and care plan dated June 7, 2022, included medication management, blood glucose monitoring, and assistance with bathing.

R1's comprehensive assessment, dated June 7, 2022, indicated R1 used a wheeled walker, preferred to have staff standby assist during transfers, could not ambulate long distances, and had a history of falls. The assessment indicated R1 had a hospital bed and had a half bed rail on the upper left side of the bed. R1 wished to use a bed rail and it was not used in a way to restrain the resident. The assessment also indicated the rail was installed per manufacturer's directions and benefits and risks had been explained to the resident.

R1's 90 Day Review dated September 7, 2022, failed to identify, or assess the bed rail.

R1's comprehensive assessment dated October 5, 2022, identified R1 used a quarter rail on the upper left side of the bed and risk benefits had been provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30580	A. BUILDING: _____ B. WING _____	11/09/2022

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02310	Continued From page 55 R1's record failed to identify the Halo Safety Ring device which was currently installed on the resident's bed, lacked an assessment of the device, and there was no evidence risks and benefits for use of the device had been provided to the resident and/or resident's representative. On a form, identified as apartment rounding on October 14, 2022, maintenance coordinator (MC)-L identified he had inspected R1's device. It was the Halo device and was installed according to manufacturer guidelines and it was tight against the mattress. On November 9, 2022, at 10:42 a.m., registered nurse (RN)-D stated R1's record lacked an assessment of the Halo Safety Ring and there was no evidence the risks and benefits had been provided for that device. She was unaware of the exact installation date but believed it to be approximately October 5, 2022, when the comprehensive assessment was completed. RN-D stated the licensee's policy should have been followed which included an assessment of the device and risks/benefits given to the resident or responsible party at the time the device was installed. The licensee's Bed Rail Expectations policy, dated August 17, 2022, identified "All communities will only utilize the halo style bed rail for any needed use of bed rails for any resident. The nurse in the community will complete the bed rail assessments and any other necessary assessments prior to implementation of said bed rail." "If a resident is voicing or showing difficulty with repositioning, sitting up, etc, the nurse shall be notified. Bed rails will only be used to promote	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 56	02310		

comfort, assist in mobility and assist with positioning. Any other use of bed rails will be prohibited. Additionally, the policy indicated the following:
ASSESSMENT FREQUENCY
Prior to implementation of a halo bed rail, an initial bed rail assessment is completed. The assessment should be repeated again:
- with any change of condition
- annually
- with discontinuation
MONTHLY AUDIT REQUIREMENTS
At a minimum of monthly, director/designee shall walk through each apartment in the community, reviewing for bed rails and must:
- Complete Bed Rail Audit Form including date of audit, person auditing each apartment, apartment reviewed (walk through of each apartment is expected), side rail present (yes/no), type of rail in place (see guidance if it is NOT halo style), if rail is in place, is it installed according to manufacturer instructions/guidelines, additional information, action taken. If noted: ensure Halo style rail is in place, if another style, immediately remove rail, follow-up shall be made to the resident/responsible party and vendor if applicable. After a minimum of verbal review and approval, change non-compliant rail to the Halo style rail. If communities Halo rail is put in use, ensure one is ordered for the resident. This is a cost to the resident. Document findings on Bed Rail Audit Form."

The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for

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02310	Continued From page 57 the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *11/08/22*
Time: 10:09:42
Report: 8044221407

Food and Beverage Establishment Inspection Report

Location:
Traditions Of Owatonna Ii Llc
150 24th Street Ne
Owatonna, MN55060
Steele County, 74

Establishment Info:
ID #: 0038713
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074550700
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.

3-800 Highly Susceptible Populations

3-801.11B ** Priority 1 **

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

Unpasteurized eggs used for sunny side up eggs.

Eggs in cooler maybe used for fried eggs and baking until pasteurized eggs are received.

Comply By: 11/08/22

3-500A Microbial Control: cooling

3-501.15A ** Priority 2 **

MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.

Soup cooled in deep, plastic, covered tub.

Comply By: 11/08/22

3-500A Microbial Control: cooling

3-501.15B ** Priority 2 **

MN Rule 4626.0390B Loosely cover containers of cooling food and arrange in cold holding equipment in a manner to maximize heat transfer through the container walls.

Egg salad cooling in covered container.

Cover removed while on site.

Comply By: 11/08/22

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

Handwashing sink not sealed to wall in dishwashing area or in serving kitchen.

Comply By: 11/08/22

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

Soiled interiors in microwave in serving kitchen.

Comply By: 11/09/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

Soiled floors in dishwasher area and in serving kitchen.

Comply By: 11/11/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.16

MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.

Wet mop sitting in mop sink.

Comply By: 11/08/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Dispenser
Violation Issued: No

Chlorine: = 50 ppm at 117 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 35.0 Degrees Fahrenheit - Location: WIC
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35.6 Degrees Fahrenheit - Location: Chicken noodle soup in WIC
Violation Issued: No

Process/Item: Cooling
Temperature: 59.6 Degrees Fahrenheit - Location: Egg salad @ 10:52 am
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40.1 Degrees Fahrenheit - Location: Milk in serving kitchen fridge
Violation Issued: No

Process/Item: Cold Holding
Temperature: 33.0 Degrees Fahrenheit - Location: Serving kitchen fridge
Violation Issued: No

Process/Item: Hot Holding
Temperature: 141.8 Degrees Fahrenheit - Location: Hamburger patties
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	2	4

HRD inspection conducted with lead surveyor Bruce Melchert and Stacy Haag. Inspection report reviewed with kitchen manager, Linda.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044221407 of 11/08/22.

Certified Food Protection Manager: Linda K. Polkow

Certification Number: FM106974 Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
Inspector signed for Linda

Signed: _____

Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us