



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

August 10, 2023

Licensee

Oak Park Place Of Albert Lea
1615 Bridge Avenue
Albert Lea, MN 56007

RE: Conditional License Number 408344
Health Facility Identification Number (HFID) 30707
Project Number(s) SL30707015

Dear Licensee:

On July 19, 2023, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed March 13, 2023. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective August 10, 2023.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the March 13, 2023 survey.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's 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).

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

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

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

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

Oak Park Place Of Albert Lea

August 10, 2023

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

Sincerely,

A handwritten signature in black ink, reading "Lindsey L. Krueger". The signature is written in a cursive, flowing style.

Lindsey L. Krueger, RN, BS, MA

Assistant Division Director

Minnesota Department of Health

Health Regulation Division

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30707	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/19/2023
NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL30707015-1 On July 17, 2023, through July 19, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on March 13, 2023. At the time of the survey, there were 43 residents: 43 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required	{0 480}			
{0 630} SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for three of six residents (R1, R2, R19). 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	{0 630}			

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{0 630}	Continued From page 2 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included Parkinson's disease and Alzheimer's disease. R1 was admitted to the facility under the comprehensive license on June 15, 2021, and on August 1, 2021, under the assisted living with dementia care (ALFDC) license. R1's Individual Abuse Prevention Plan dated June 25, 2023, identified R1 had vulnerabilities due to chronic disease of dementia, and R1 was unable to manage his finances. However, it identified that R1 was not at risk for abuse from others. In addition, R1's Individual Abuse Prevention Plan failed to identify specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R2 R2's diagnoses included diabetes mellitus type 2 and mild cognitive impairment. R2 was admitted to the facility under the ALFDC license on August 13, 2021. R2's Individual Abuse Prevention Plan dated June 25, 2023, identified R2 had vulnerabilities due to chronic disease of diabetes mellitus type 2 and "mild MR" [mental retardation] and R2 was unable to manage his finances. However, it	{0 630}			

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{0 630}	Continued From page 3 identified that R2 was not at risk for abuse from others. In addition, R2's Individual Prevention plan failed to identify specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R19 R19's diagnoses included diabetes mellitus (inability to regulate blood sugar), hypertension (high blood pressure), hemiplegia (weakness or inability to effectively use half of the body), and anxiety. R19 was admitted to the facility under the ALFDC license on April 10, 2023. R19's Individual Abuse Prevention plan dated June 26, 2023, identified R19 had vulnerabilities due to chronic conditions, pain, illness, and disability. However, it identified that R19 was not at risk for abuse from others. On July 19, 2023, at 12:05 p.m. registered nurse (RN)-Q stated all residents in the facility were considered vulnerable adults and were at risk for abuse by others, including other vulnerable adults. The IAPPs would be reviewed and corrected, and nurses would receive additional education when completing the IAPPs. The licensee's Individual Abuse Prevention Plan policy dated April 17, 2023, indicated Oak Park Place will develop and implement an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adults.	{0 630}			

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{0 630}	Continued From page 4 No further information was provided.	{0 630}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required	{0 790}			
{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	{0 810}			

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{0 810}	Continued From page 5 evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required	{0 810}			
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	{01620}			

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{01620}	Continued From page 6 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 interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for two of five residents (R1, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1 was admitted to the facility under the comprehensive license on June 15, 2021, and later the assisted living with dementia care (ALFDC) license on August 1, 2021.	{01620}			

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{01620}	Continued From page 7 R1's Service Plan (Addendum A) dated July 17, 2023, indicated R1 received services to include medication administration, assistance with dressing, showering, grooming, toileting and assistance with the treatment of compression stockings. R1's Comprehensive Assessments since March 2023 evaluations were requested. Comprehensive Assessments dated March 10, 2023, and June 29, 2023, were provided. The June 29, 2023, assessment was 111 days from the previous assessment date, exceeding 90 calendar days. R5 R5 began receiving services under the licensee's comprehensive license on December 15, 2015, and later under the licensee's assisted living with dementia care license since August 1, 2021. R5's unsigned and undated, Service Plan (Addendum A) indicated R5 received services to include dressing, grooming, shower assistance, and medication administration. R5's Comprehensive Assessments since March 2023, were requested. Assessments dated March 10, 2023, and June 14, 2023, were provided. The June 14, 2023, assessment was 96 days after the previous assessment date, exceeding 90 calendar days. On July 19, 2023, at 12:30 p.m. registered nurse (RN)-P stated the assessments provided were all she was able to find and would be accurate. The licensee's Assessments, Reviews and Monitoring policy dated April 13, 2023, indicated the ongoing resident reassessment and	{01620}			

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{01620}	Continued From page 8 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.	{01620}			
{01640} SS=E	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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included a date and signature or other authentication by the resident and the facility to document	{01640}			

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{01640}	Continued From page 9 agreement on the services provided for five of eight residents (R1, R2, R5, R6, R7). 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: R1 R1's Service Plan (Addendum A) dated July 17, 2023, included the services of medication administration, assistance with compression stockings, assistance with dressing, grooming, showers and toileting, and safety checks. R1's Service Plan was signed by R1, but lacked a signature by a licensee representative. R2 R2's undated, Service Plan (Addendum A) included the services of medication administration, blood glucose monitoring (checking blood sugar), and safety checks. R2's Service plan was signed by R2, but lacked a date and signature by a licensee representative. R5 R5's undated, Service Plan (Addendum A) included the services of medication administration, assistance with dressing, grooming, showers, and behavior monitoring. R5's Service Plan lacked a signature and date by the resident/resident representative and by a	{01640}			

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{01640}	Continued From page 10 licensee representative. R6 R6's Service Plan (Addendum A) dated July 13, 2023, included the services of medication administration, assistance with grooming, showering, toileting, ambulation/escorts, compression stockings and safety checks. R6's Service Plan included a signature and date by R6's resident representative, but lacked a signature/date by a licensee representative. R7 R7's Service Plan (Addendum A) dated July 11, 2023, included the services of medication administration, insulin administration, blood glucose monitoring, assistance with showers and toileting, and safety checks. R7's Service Plan included R7's signature, but lacked a signature by a licensee representative. On July 19, 2023, at 12:15 p.m. assisted living director in residency (ALDIR)-S stated since the previous survey, the previous licensed assisted living director (LALD) had completed most of the resident service plans with the residents or their designated representatives. Many service plans were sent out for signatures, and she was now the ALDIR and would need to review and sign them as the licensee representative. The licensee's Service Plan policy dated April 13, 2023, indicated the Service Plan and any revisions would include a signature or other authentication by the licensee and by the resident or resident's representative, documenting agreement on the services to be provided. No further information was provided.	{01640}			

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{01730} SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed	{01730}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
(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
{01730}	Continued From page 12 when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan included all required content for one of six residents (R19). 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: R19 R19 diagnoses included diabetes mellitus (when the body cannot adequately manage blood sugar), depression, anxiety disorder, and hemiplegia/ hemiparesis following a cerebral infarction (weakness and inability to use half of the body following a stroke). R19's Service Plan dated July 11, 2023, indicated R19 received medication administration. On July 18, 2023, at 8:50 a.m. unlicensed personnel (ULP)-T was observed to complete a blood sugar check for R19. On July 19, 2023, at 10:20 a.m. ULP-U stated	{01730}			

Minnesota Department of Health

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{01730}	Continued From page 13 although R19 mostly self administered her oral medications, she still asked for assistance from the ULP for her topical diclofenac gel (for pain) to her thigh. R19's Medication Administration Record (MAR) dated June 2023, indicated she received one medication for cholesterol, two for diabetes mellitus, one for thyroid, two for high blood pressure, one for gastric reflux, one blood thinner, one for depression, one oral medication for pain, one injectable medication for emergency management of low blood sugar, two topical (on the skin) pain medications and one topical antifungal powder. R19's Individualized Medication Management Plan dated July 8, 2023, indicated delegated medication tasks for ULP included oral administration but lacked the delegated tasks of topical medications and an injectable medications. On July 19, 2023, at 12:45 p.m. registered nurse (RN)-P reviewed R19's Medication Plan and confirmed it did not include the delegated administration of a topical medication and an injectable medication. The licensee's Medication Management Individualized Plan policy dated April 13, 2023, indicated the medication plan would include the identification of medication management tasks that may be delegated to unlicensed personnel.	{01730}			
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 14 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 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 an individualized treatment management plan to include all required content for one of four residents (R19). This practice resulted in a level two violation (a violation that did not harm a resident's health or	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 15 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). R19 R19's diagnoses included diabetes mellitus (inability to regulate blood sugar), hypertension (high blood pressure), hemiplegia (weakness or inability to effectively use half of the body), and anxiety. R19's Service Plan (Addendum A) dated July 11, 2023, included blood glucose (blood sugar) checks. On July 18, 2023, at 8:50 a.m. unlicensed personnel (ULP)-T was observed to complete a blood sugar check for R19. On July 19, 2023, at 10:20 a.m. ULP-U stated R19 received daily blood sugar checks by staff and assistance with a lower extremity brace. R19's Medication Administration Record (MAR) dated June 2023, included "check blood glucose once daily", but lacked directions or parameters for when to notify the nurse. R19's Individualized Treatment/Therapy Management Plan dated June 26, 2023, included the treatment of lower extremity brace assistance, but lacked the treatment of blood glucose checks and lacked parameters when ULP should contact the nurse. On July 19, 2023, at 12:30 p.m. registered nurse	{01940}			

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{01940}	Continued From page 16 (RN)-P reviewed R19's record contents and stated the treatment plan lacked the treatment of blood glucose checks and lacked parameters for when ULP should notify nursing. The licensee's Treatment and Therapy Management Plan dated April 13, 2023, indicated the plan would identify the treatment or therapy tasks that would be delegated to unlicensed personnel and procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. No further information was provided.	{01940}			
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action required	{02040}			
{02110} SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures	{02110}			

Minnesota Department of Health

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{02110}	Continued From page 17 required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and 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 policies and procedures	{02110}			

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{02110}	Continued From page 18 required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in for six of six residents (R1, R2, R5, R6, R19, R20). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings included: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2022. R1, R2, R5, R6, R19, and R20's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic	{02110}			

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{02110}	Continued From page 19 medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On July 18, 2023, at 2:19 p.m. registered nurse (RN)-Q confirmed they had not provided residents/legal representative or designated representative the dementia policies and procedures at the time of move-in. RN-Q provided the surveyor with a copy of the admission paperwork which was given to residents/legal representative or designated representative at the time of move-in. RN-Q confirmed though the packet included some information related to the licensee's dementia services, the dementia policies had not been provided to the residents, nor their legal and designated representative at the time of move in, or after they had acquired the required dementia care policies. The licensee's Assisted Living with Dementia Care Additional Required Policies policy dated April 10, 2023, indicated "Because [licensee name] has an Assisted Living with Dementia Care license, in addition to the policies and procedures required for the facility written policies and procedures must address the following list. In addition, these policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of	{02110}			

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{02110}	Continued From page 20 move-in. The policies can be provided in electronic format if desired." No further information provided.	{02110}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

May 10, 2023

Licensee

Oak Park Place Of Albert Lea
1615 Bridge Avenue
Albert Lea, MN 56007

RE: Conditional License Number 408344
Health Facility Identification Number (HFID) 30707
Project Number(s) SL30707015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 13, 2023, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **August 8, 2023**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

MDH may assess fines based on the level and scope of the correction orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is \$18,500.

MDH is not imposing these fines against your license at this time.

St - 0 - 0250 - 144g.20 Subd. 1 - Conditions = \$500.00

St - 0 - 0350 - 144g.30 Subd. 8 - Notice Of Noncompliance = \$3,000.00

St - 0 - 1290 - 144g.60 Subd. 1 - Background Studies Required = \$3,000.00

St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring = \$3,000.00

St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration = \$3,000.00

St - 0 - 1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy = \$3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = \$3,000.00

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes Chapter 144G.**

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

CONDITIONAL LICENSE ISSUED:

MDH will issue Oak Park Place Of Albert Lea a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Oak Park Place Of Albert Lea is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.
- b. **No new admissions:** Oak Park Place Of Albert Lea will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Oak Park Place Of Albert Lea must provide MDH:
 - i. A list of the names and birthdates of any individuals Oak Park Place Of Albert Lea is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident

3. Current payment source for services
 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- c. **Consultant:** Oak Park Place Of Albert Lea will contract with an RN to provide consultation concerning all resident(s) to whom Oak Park Place Of Albert Lea provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Oak Park Place Of Albert Lea. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Oak Park Place Of Albert Lea and MDH must review the RN's credentials and approve the selection. Oak Park Place Of Albert Lea is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Oak Park Place Of Albert Lea in an effort to help Oak Park Place Of Albert Lea align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Oak Park Place Of Albert Lea will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.
- d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Oak Park Place Of Albert Lea and the RN consultant about a change. Each report will be electronically submitted to Jodi Johnson, Supervisor, State Evaluation Team, Health Regulation Division, at jodi.johnson@state.mn.us. Jodi Johnson can be reached at 507-344-2730 (office) with questions about reports. The content of the reports will include information such as:
- i. Progress towards correction of orders;
 - ii. Observations of staff delivering assisted living services and the level of competency observed;
 - iii. Conversations with residents and family members about satisfaction with assisted living services;
 - iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
 - v. Overall impressions about the quality of the assisted living services delivered;
 - vi. Overall impressions about the dignity with which the residents and their family

- members are treated;
- vii. Concerns; and
- viii. Any other information requested by MDH or considered important by the RN consultant(s).

- e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Oak Park Place Of Albert Lea to correct the violations cited during the survey as well as to determine the overall practice of Oak Park Place Of Albert Lea in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- g. **Corrective Action Plan:** Oak Park Place Of Albert Lea will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
 - i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Oak Park Place Of Albert Lea is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Oak Park Place Of Albert Lea is in substantial compliance on the follow up survey, MDH will remove the conditions from Oak Park Place Of Albert Lea's assisted living facility license, and Oak Park Place Of Albert Lea will correct violations identified during the survey to come into substantial compliance. If MDH determines Oak Park Place Of Albert Lea is not in substantial compliance, MDH may take additional enforcement action against Oak Park Place Of Albert Lea, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:

Oak Park Place Of Albert Lea

May 10, 2023

Page 6

Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing 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
Health.HRD.Appeals@state.mn.us

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

If you have any questions, please contact Jodi Johnson directly at: 507-344-2730.

Sincerely,

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

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30707	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/13/2023
NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30707015-0 On March 6-13, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 45 active residents; 44 of whom were receiving services under the Assisted Living with Dementia Care license. 0350: An immediate correction order was issued on March 7, 2023. The immediacy was removed; however, non-compliance remains at a level 3, widespread scope (I). 1290: An immediate correction order was issued on March 7, 2023. The immediacy was removed; however, non-compliance remains at a level 3, pattern scope (H). 1620: An immediate correction order was issued on March 10, 2023. The immediacy was	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.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1 removed; however, non-compliance remains at a level 3, widespread scope (I). 1750: An immediate correction order was issued on March 8, 2023. The immediacy was removed; however, non-compliance remains at a level 3, widespread scope (I). 1950: An immediate correction order was issued on March 8, 2023. The immediacy was removed; however, non-compliance remains at a level 3, widespread scope (I). 2310: An immediate correction order was issued on March 10, 2023. The immediacy was removed; however, non-compliance remains at a level 3, isolated scope (G).	0 000			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in	0 250			

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0 250	Continued From page 2 any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements	0 250			

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0 250	Continued From page 3 of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 6, 2023, at 11:45 a.m., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess	0 250			

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0 250	Continued From page 4 [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police,	0 250			

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0 250	Continued From page 5 local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by authorized agent on May 31, 2022. The licensee had an assisted living license issued	0 250			

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0 250	Continued From page 6 on August 1, 2022, with an expiration date of August 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - handling complaints regarding staff or services provided by staff; - conducting initial evaluations of residents' needs and the providers' ability to provide those services; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - ensuring that nurses and licensed health professionals have current and valid licenses to practice; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; and - supervision of unlicensed personnel performing	0 250			

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0 250	Continued From page 7 delegated tasks. As a result of this survey, the following orders were issued 0510, 0630, 0660, 1290, 1370, 1380, 1470, 1500, 1540, 1620, 1700, 1730, 1750, 1760, 1770, 1820, 1830, 1880, 1890, 1910, 1940 1950, and 2240 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. In addition, the licensee failed to provide requested information in a timely manner when it was requested by the surveyors. This caused a delay in completing the survey process in a timely manner. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 350 SS=I	144G.30 Subd. 8 Notice of noncompliance If the commissioner finds that the applicant or a facility has not corrected violations by the date specified in the correction order or conditional license resulting from a survey or complaint investigation, the commissioner shall provide a notice of noncompliance with a correction order by e-mailing the notice of noncompliance to the facility. The noncompliance notice must list the violations not corrected. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to comply with the plan of correction from an immediate order issued on	0 350			

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0 350	Continued From page 8 March 7, 2023, for background study clearance. This resulted in an immediate order on March 13, 2023, at 10:40 a.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 7, 2023, the licensee was issued an immediate order for failure to ensure a proper background clearance was completed for all licensee staff. The immediacy was lifted on March 8, 2023, at 2:56 p.m. On March 8, 2023, at 12:05 p.m. licensed assisted living director (LALD)-A provided a plan of correction via email to include: "Plan of Correction / Revised 3/8/23 Audit/compare roster of eligible employees in Net Study to our employee roster. Compose a list of employees that need to have their background study re-submitted. Meet with DHCS [director of health care services] to revise a schedule reflecting our need to have those employees supervised until their background study check is cleared. DOH [director of housing] will immediately begin re-submitting the necessary background study checks on Netstudy.	0 350			

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0 350	Continued From page 9 DOH will contact those employees and inform them of the situation and tell them to check their email for further instructions. Also inform them that they are to set up an appointment to be finger-printed and photographed ASAP! [Provider name] will drive employees who need a ride to the designated photo/print location. It is at the YMCA in Albert Lea. DOH will call the YMCA first thing in the morning on 03/08/2023. And ask if it is possible for them to schedule the [Provider name] employees ASAP. It is our intent to get this done ASAP. Changes will be put in place to prevent this from happening again. DHCS will be cross-trained so that there are 2 people in our facility that can use and have access to Netstudy. An audit will be put into place as a system to follow-up on employees that have background study checks pending. It will be the responsibility of the DOH to perform the audits on a weekly basis. Education of Staff: All staff will read and sign off that they have read and understand the notice posted regarding the background study issue. The notice is stressing the fact that the supervision of employees is direct supervision. Meaning that any employee that is not cleared and eligible on NETStudy must have someone that is cleared, be directly with them at all times (not just in the building or in the same unit). Think the "buddy-system" This information will be passed along at shift change and put in PCC [point click care] under	0 350			

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0 350	Continued From page 10 Communication Notes. A sign will be posted in the break room as well as by the timeclock. We are asking employees to sign off at the end of their shift who (if anyone) they were supervising. This will hold accountability. We will have blank forms by the time clock for this purpose. DHCS & Community RN [registered nurse]- Have revised the schedule to ensure proper coverage. Our Receptionist and Community RN will call any employees affected by the schedule changes. DHCS put a call into the Netstudy program to see what (if anything) they could do to assist with speeding up the process of clearing our background studies. DOH called the local photo/finger print location. They have openings all afternoon today 3/8/23. Their representative told us to send people when we are able and not to worry about making appointments. They will make sure all employees from [Provider name] get taken care of." ULP-D/ULP-K On March 10, 2023, at 6:36 a.m. ULP-D was observed, unsupervised, at a medication cart on the second floor setting up medications for administration. At 6:38 a.m., ULP-K exited a resident room (unsupervised) and approached the medication cart. At 6:39 a.m., ULP-D and ULP-K walked down the hallway and into a resident room. ULP-D and ULP-K failed to have a cleared background check and failed to have supervision of a staff member with an eligible background check. On March 10, 2023, at 8:45 a.m. LALD-A stated	0 350			

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0 350	Continued From page 11 "any staff that did not have background check clearance should always have been supervised by another staff member. Due to weather related road conditions, a staff that was supposed to supervise ULP-D was late getting to work. Staff still should have had a different staff member supervising them." V-N On March 12, 2023, at 11:45 a.m. the surveyor observed ULP-K in the facility's memory care unit feeding an unidentified resident in the dining area. ULP-K required direct supervision because they did not have a cleared background study. ULP-M (assigned to provide supervision) was observed in the dining area as well, serving meals. Additionally, volunteer (V)-N was observed assisting serving meals. ULP-M stated V-N was her daughter, and was there as part of a program as an intern at a local community college. At 11:50 a.m. the surveyor observed ULP-M outside of the memory care area serving meals from a cart to several residents' apartments on the first floor of the assisted living. ULP-M stated V-N was in the memory care unit with ULP-K (to provide supervision) and stated V-N had completed a background study for another job and school, and had that proof at home. At 12:05 p.m. the surveyor attempted to call LALD-A, but was unable to reach them and was unable to leave a message (full voice mail box). At 12:30 p.m., the surveyor contacted health regulation division (HRD) supervisor who verified V-N had a background study completed in 2022 for another job and school; however, she was not affiliated with the licensee.	0 350			

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0 350	Continued From page 12 At 12:35 p.m. LALD-A arrived in the memory care unit to talk to ULP-M about some schedule needs. LALD-A stated V-N had a background clearance but she had not been affiliated with the licensee. LALD-A stated her expectation was for ULP-M to stay in direct contact with ULP-K at all times, and V-N was a "learner," not an employee. LALD-A stated she (LALD-A) was there to supervise a staff who had not yet had a cleared background study and stated she would ensure the remaining on-duty staff understood their role and responsibility if assigned to supervise a staff without a background clearance. On March 13, 2023, at 10:00 a.m. LALD-A stated the college program V-N was associated with did not have a contract with the licensee and had only shadowed in the facility a couple weekends thus far. V-N was classified as a volunteer. LALD-A stated she affiliated V-N's background study with the licensee, and had completed this today (March 13, 2023). LALD-A stated she was aware V-N was going to be onsite over the weekend and had given direction that V-N was to shadow ULP-K at all times. LALD-A stated she was told verbally V-N had completed a background study for her previous job and school, and did not follow up with checking it herself. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On March 14, 2023, at 2:46 p.m. the immediacy was removed based on observations by the surveyors and record reviews by the evaluation	0 350			

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0 350	Continued From page 13 supervisor; however, non-compliance remains at a scope and level of I. TIME PERIOD FOR CORRECTION: Two (2) Days	0 350			
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a Uniform Disclosure of Assisted Living Service and Amenities (UDALSA) as required. This had the potential to affect all 45 residents living in the facility. This practice resulted in a level one violation (a	0 430			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30707	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/13/2023
NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007			
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0 430	Continued From page 14 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 began receiving services under the comprehensive home care license on June 15, 2021, and under the assisted living with dementia care (ALFDC) license on August 1, 2021. R2 began receiving services under the ALFDC license on August 13, 2021. R5 began receiving services under the comprehensive home care license on February 12, 2021, and under the ALFDC license on August 1, 2021. R6 began receiving services under the ALFDC license on October 15, 2022. R1, R2, R5, and R6's records lacked evidence of being provided with the UDALSA. On March 7, 2023, at 11:09 a.m. licensed assisted living director (LALD)-A stated they used a Uniform Consumer Information guide and believed that to be the UDALSA. The licensee did not have a UDALSA completed; therefore, no residents were provided with a UDALSA. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430			

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0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing plan contained the required content and a 24 hour staff schedule was posted as required. This had the potential to affect all residents, staff, and visitors.	0 470			

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0 470	Continued From page 16 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 7, 2023, from 6:50 a.m. until 8:18 a.m., unlicensed personnel (ULP)-D and ULP-E were observed administering medications and treatments to residents. On March 7, 2023, at 8:18 a.m. the following was observed: - a white board above the medication cart on the second floor in the assisted living area. It identified the date and shift care manager as unlicensed personnel (ULP)-E and shift PCA (unlicensed personnel) was blank. - a white board above the medication cart on the first floor in the assisted living area. It identified the date and shift care manager as unlicensed personnel (ULP)-E and shift PCA as ULP-O. The posted schedule lacked the following: - direct-care staff work schedules for each direct-care staff member showing all hours worked; - direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building	0 470			

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0 470	Continued From page 17 On March 7, 2023, at 11:54 a.m. licensed assisted living director (LALD)-A stated the staff on duty in the assisted living that day were ULP-E, ULP-D, and ULP-J. The information was not updated and did not contain the required content. STAFFING PLAN The licensee held an assisted living with dementia care license, and was licensed for a capacity of 62 residents, and had a current census of 45 residents to include 15 residents in the memory care unit. The licensee failed to develop and implement a staffing plan for determining it's staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. On March 7, 2023, at 6:45 a.m. registered nurse (RN)-C stated although she managed most of the schedule, LALD-A should have the staffing plan. RN-C stated she didn't know she was to evaluate the staffing plan twice a year. On March 7, 2023, at 9:45 a.m. director of health care services-registered nurse (DHCS-RN)-B stated she had nothing to do with the schedule, RN-C managed all of it, and was not aware of a staffing plan.	0 470			

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0 470	Continued From page 18 On March 7, 2023, at 10:00 a.m. LALD-A indicated the licensee had not developed a staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report	0 480			

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0 480	Continued From page 19 dated March 7, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control when they failed to properly disinfect shared blood glucose meters between residents. This had the potential to affect all residents who received blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 510			

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0 510	Continued From page 20 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents. The findings include: On March 7, 2023, at 6:50 a.m. unlicensed personnel (ULP)-E attempted to check R3's blood glucose, but his personal meter was not working. ULP-E used a community shared blood glucose meter to check R3's blood glucose. ULP-E stated they used this meter for residents when a resident's meter was not working. After use, ULP-E placed the shared blood glucose meter back in the storage bag and placed it on the medication cart. ULP-E failed to disinfect the blood glucose meter. When questioned about cleaning the meter, ULP-E stated she used an alcohol prep pad to clean it. ULP-E then took out the blood glucose meter, used an alcohol prep pad to wipe it down, placed it back in the storage bag and put it back into the medication cart. On March 9, 2023, at 8:55 a.m. director of health care services/registered nurse (DHCS/RN)-B stated she trained staff to use an alcohol prep pad to clean the meter. It would be important to properly disinfect a community use blood glucose meter between residents to prevent the spread of bloodborne pathogens. The Embrace Pro user manual dated December 2019, identified "Clean the outside of the meter using a moist (not wet) cloth or tissue with isopropyl alcohol or mild detergent with water." The manual did not identify the meter to be for multiple patient use or identify an environmental protection agency (EPA) approved cleanser for disinfecting the device.	0 510			

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0 510	Continued From page 21 The licensee's Disinfecting Reusable Equipment and Environmental Surfaces Policy undated, identified "Reusable equipment and environmental surfaces will be properly disinfected after use. Whenever possible, clients will have their own reusable equipment and the equipment will not be shared with other clients or residents." "Glucometers must be cleaned after each use following the manufacturer's instructions." Centers for Disease Control (CDC)'s Frequently Asked Questions (FAQs) regarding Assisted Blood Glucose Monitoring and Insulin Administration dated March 2, 2011, identified the following: - Infectious agents, such as HBV [hepatitis B virus], can be transmitted through indirect contact transmission, even in the absence of visible blood. If blood is transferred from the patient to the meter, and the meter is not cleaned and disinfected after use, subsequent patients can be exposed to this blood when the meter is used on them. Indirect contact transmission can also occur even if the patient never directly contacts the meter. Healthcare personnel hands can become contaminated with blood at various points while performing assisted blood glucose monitoring including pricking the patient ' s finger or handling the test strip. Blood can then be transferred to the meter when healthcare personnel handle the meter to obtain the reading. If the meter is not cleaned and disinfected after use, the blood remaining on the meter can be transferred to subsequent patients via healthcare personnel hands when they handle the meter and then assist with fingerstick procedures. Numerous outbreaks have implicated this mechanism in the spread of HBV infections.	0 510			

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0 510	Continued From page 22 - Please note that 70% ethanol solutions are not effective against viral bloodborne pathogens and the use of 10% bleach solutions may lead to physical degradation of your device. - Healthcare personnel should consult the manufacturers of blood glucose meters in use at their facilities to determine what products, meeting the criteria specified by the FDA, are compatible with their meter prior to using any EPA-registered disinfectant for disinfection purposes. If manufacturers are unable to provide this information then the meter should not be used for multiple patients. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.	0 550			

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0 550	Continued From page 23 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure as well as the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 6, 2023, at 1:30 p.m. the surveyor toured the facility with licensed assisted living director (LALD)-A. There was a posting in a plastic file holder the facility foyer by the community mailbox area which included the numbers for the regional Office of Ombudsman for Long-Term Care and for the Office of Facility Health Complaints (OFHC) at the Minnesota Department of Health. The licensee failed to post the required information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who	0 550			

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0 550	Continued From page 24 are responsible for handling resident grievances. Additionally, the posting lacked contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities and lacked information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. On March 7, 2023, at 8:50 a.m. LALD-A stated she had the posting as indicated in the file holder, but had not posted the required content as stated above. LALD stated the Minnesota Bill of Rights was posted at the elevator and had thought this was sufficient. LALD-A stated she would start fixing the missing content right away. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced	0 580			

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0 580	Continued From page 25 by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current clients, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 6, 2023, at 12:00 p.m. during entrance conference, licensed assisted living director (LALD)-A stated the licensee has a committee that meets quarterly to review complaints and various topics. She stated the meetings should have been documented. LALD-A was unable to recall the last meeting. Meeting notes and agendas were requested, but were not provided. The licensee's undated, Quality Management Plan, Reference: Home Care Law-MN statute 144.470, subd. 3 policy read the Home Care Director will develop a continuous quality improvement and management program to maintain the agency's continuous performance improvement efforts, consistent with current professional standards and the highest quality services for clients. All staff will be involved in the implementation of performance improvement efforts.	0 580			

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0 580	Continued From page 26 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for four of four residents (R1, R2, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	0 630			

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0 630	Continued From page 27 The findings include: R1 R1's diagnoses included Parkinson's disease and Alzheimer's disease. R1 was admitted to the facility under the comprehensive license on June 15, 2021, and on August 1, 2021, under the assisted living with dementia care (ALFDC) license. On March 7, 2023, between 7:48 - 8:15 a.m. the surveyor observed unlicensed personnel (ULP)-D putting on TED (thrombo-embolic deterrent) stockings (used to reduce swelling and prevent blood clots) and administer eye drops to R1. R1's Vulnerability Assessment/Abuse Prevention Plan dated March 4, 2023, identified R1 had vulnerabilities due to chronic disease of dementia, and R1 was unable to manage his finances. However, it identified that R1 was not at risk for abuse from others. R1's undated, Service Plan/Care Plan failed to identify specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R2 R2's diagnoses included diabetes mellitus type 2 and mild cognitive impairment. R2 was admitted to the facility under the ALFDC license on August 13, 2021. On March 17, 2023, at 7:16 a.m. the surveyor observed ULP-E check R2's blood glucose,	0 630			

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NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007			
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0 630	Continued From page 28 administer insulin, and administer oral medications. R2's Vulnerability Assessment/Abuse Prevention Plan dated February 10, 2023, identified R2 had vulnerabilities due to chronic disease of diabetes mellitus type 2 and "mild MR" [mental retardation] and R2 was unable to manage his finances. However, it identified that R2 was not at risk for abuse from others. R2's undated, Service Plan/Care Plan failed to identify specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R5 R5's diagnoses included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, depression, and anxiety. R5 began receiving services under the licensee's comprehensive license on December 15, 2015, and on August 1, 2021, under the licensee's assisted living with dementia care license. On March 7, 2023, at 8:30 a.m. the surveyor observed registered nurse (RN)-C to administer oral medications to R5 while she was at the dining room eating breakfast. R5's Vulnerability Assessment/Abuse Prevention Plan dated February 5, 2023, indicated R5 had vulnerabilities due to chronic disease of irritable bowel syndrome (IBS), chronic kidney disease, anxiety and hypertension, and identified R5 was unable to manage finances, was forgetful, and lived in a secured memory care unit as she was a	0 630			

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0 630	Continued From page 29 wandering/elopement risk. However, it identified R5 was not at risk for abuse from others. R5's undated and unsigned Service Plan/Care Plan failed to identify specific measures to be taken to minimize the risk of abuse to her by others. R6 R6's diagnoses included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R6 began receiving services under the licensee's assisted living with dementia care license on October 15, 2022. On March 7, 2023, at 7:20 a.m. the surveyor observed ULP-F assist with her TED stockings to both lower extremities. R6's Vulnerability Assessment/Abuse Prevention Plan dated January 14, 2023, indicated R6 had vulnerabilities due to the chronic conditions of dementia and hypertension and identified R6 could not call for help, was forgetful, unable to self manage finances, lived in a memory care unit and was an elopement risk. Furthermore, it indicated she was unable to report abuse/neglect/concerns; however, it identified R6 was not at risk for abuse from others. R6's unsigned and undated, Service Plan/Care Plan failed to identify specific measures to be taken to minimize the risk of abuse to her by others. On March 9, 2023, at 12:00 p.m. RN-C stated, "We were instructed to check the option "no" [in	0 630			

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0 630	Continued From page 30 the Vulnerability Assessment], but I understand all residents are vulnerable to abuse by others, including other residents." The licensee's undated, Vulnerable Adult Policy read Under MN Statute Â§626.5572, Subd. 21, any person 18 years of age or older who is a home care client is categorically defined as a vulnerable adult. This section of law includes a functional definition of a vulnerable adult: a person who "regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction: -that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and -because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 630			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number	0 640			

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0 640	Continued From page 31 for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and 911 emergency number as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 6, 2023, at 1:30 p.m. during a facility tour, the surveyor noted a plastic file holder in the facility's foyer by the community mailbox area which included the numbers for the regional Office of Ombudsman for Long-Term Care and for the Office of Facility Health Complaints (OFHC) at the Minnesota Department of Health; however, there was no evidence of posting the MAARC hotline in the common areas of the facility or 911 phone number. On March 7, 2023, at 8:45 a.m. licensed assisted	0 640			

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0 640	Continued From page 32 living director (LALD)-A confirmed the content noted above was not posted as required, and would start working on getting them in place. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 650 SS=A	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 650			

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0 650	Continued From page 33 review, the licensee failed to ensure employee records included a job description with the required content for one of four employees (director of health care services/registered nurse (DHCS/RN)-B). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at 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: DHCS/RN-B was hired on October 3, 2022, to provide direct care services to residents of the facility. DHCS/RN-B's employee record lacked evidence of a current job description which included the qualifications for the position and identification of staff providing supervision. On March 13, 2023, at 10:00 a.m. licensed assisted living director (LALD)-A confirmed DHCS/RN-B's job description did not include all the required content as noted above. The licensee's undated, Personnel policy indicated the employee file would include a current job description, which included qualifications, responsibilities and identification of supervisors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 650			

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0 650	Continued From page 34 (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment, documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of four employees (director of health care services-registered nurse (DHCS/RN-B) and failed to provide TB training to employees. This practice resulted in a level two violation (a	0 660			

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0 660	Continued From page 35 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: TB PREVENTION PROGRAM During the entrance conference on March 6, 2023, at 12:00 p.m. with licensed assisted living director (LALD)-A and DHCS/RN-B, a request was made to review the facility TB risk assessment. DHCS/RN-B stated RN-C was the person to check with regarding the TB risk assessment and the TB training for staff. On March 8, 2023, at 4:02 p.m. RN-C stated she was unaware of the TB risk assessment tool and the regulatory requirements. RN-C stated she had not completed a facility risk assessment, nor had provided training about TB to the licensee's staff. DHCS/RN-B DHCS/RN-B's employee record indicated a hire date of October 3, 2022. Throughout the survey, DHCS/RN-B was observed to interact with multiple residents and licensee staff. DHCS/RN-B's employee record included a completed health history and symptom screening and one TST skin test dated October 4, 2022; however, the record lacked the required second TST, or other evidence of TB screening such as a	0 660			

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0 660	Continued From page 36 blood test. On March 8, 2023, at 10:50 a.m. DHCS/RN-B stated she had her TST completed at the corporate office in Wisconsin; however, only had one TST completed. ULP-D ULP-D began providing cares under the Comprehensive home care license on May 24, 2021, and on August 1, 2021, under the Assisted Living with Dementia Care (ALFDC) license. On March 7, 2023, ULP-D was observed completing the following tasks: - at 7:21 a.m., ULP-D checked blood glucose, administered oral medications, and administered insulin to R7; and - at 8:15 a.m., ULP-D administered eye drops to R1. ULP-D's employee file lacked evidence TB training had been provided upon hire and annually. ULP-E ULP-E began providing services under the ALFDC license on December 30, 2022. On March 7, 2023, ULP-E was observed completing the following tasks: - at 6:50 a.m., ULP-E checked blood glucose, administered oral medications, and administered insulin to R3; - at 7:02 a.m., ULP-E administered oral medications to R11; and - at 7:16 a.m., ULP-E checked blood glucose, administered insulin, and administered oral medications to R2.	0 660			

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0 660	Continued From page 37 ULP-E's employee file lacked evidence TB training had been provided on hire and annually. The licensee's undated, TB Prevention and Control policy read "This agency will establish and maintain a TB prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The Minnesota Department of Health guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings (see 06-009) will be followed. Administrative Responsibility for the TB Infection Control Program: The Director of Housing or RN is responsible for establishing and maintaining the TB prevention and control program. Responsibilities include: a. Establishment of an infection control team of one or more persons. b. Completion of a written TB risk assessment for the agency using the form provided by the Minnesota Department of Health (see 06-009). c. Annual review and revision as needed of the TB risk assessment for the agency. Based on the risk assessment, Director of Housing or RN will determine the frequency of TB testing necessary for home care staff. d. Development, implementation and revision as necessary of written TB infection control procedures. If our agency is assessed as medium-risk, these TB infection control procedures will be reviewed and updated annually. If our agency is assessed as low risk for TB, these procedures will be reviewed and updated as necessary every other year. e. Education of home care staff and volunteers if applicable regarding TB signs and symptoms, our infection control plan and other communicable diseases. f. Screening of home care staff and volunteers	0 660			

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0 660	Continued From page 38 for TB. g. Maintain all reports of TB screening in the personnel files of home care employees [and volunteers.] h. If a case of suspected or confirmed TB disease is identified among staff or clients, assure that appropriate actions are taken immediately; if a case of suspected or confirmed TB is not promptly recognized and addressed, identify why and take steps to change the plan or do additional training to assure that it will be promptly addressed in the future." The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680			

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0 680	Continued From page 39 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements and failed to post the plan prominently. In addition, the licensee failed to post clearly written emergency exit diagrams. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 680			

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0 680	Continued From page 40 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On March 6, 2023, at approximately 12:00 p.m. during the entrance conference, the licensee's emergency preparedness plan and Appendix Z was discussed. Licensed assisted living director (LALD)-A stated the maintenance director (MD)-I and the director of admissions (DA)-H managed the maintenance of the emergency preparedness plan. LALD-A stated MD-I was on vacation, but DA-H would be able to review the content of Appendix Z in the coming days. During a tour of the facility on March 6, 2023, at 1:30 p.m., the surveyor observed postings on the wall of each floor and wing/memory care unit of the facility which indicated "Evacuation Route". The signage indicated the location of "you are here" with a primary route in red and a secondary route in blue both which led to stairways. The signage lacked apartment numbers and lacked a clear indication of an exit. On March 7, 2023, at 11:50 a.m. maintenance director (MD)-I verified the diagrams posted were unclear with respect to the apartment numbers and exits connected to the stairways. MD-I stated he would work on editing the diagrams. On March 8, 2023, at 12:50 p.m. the surveyor met with DA-H who stated, "I really only do stuff with the sprinkler system. [LALD-A] does more with Appendix Z. The emergency preparedness binder is kept behind the front office desk." DA-H	0 680			

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0 680	Continued From page 41 confirmed the emergency preparedness binder was not easily accessible for residents, employees, nor visitors. DA-H then provided the surveyors with a three ring binder with the current contents of their emergency plan. The contents included fire related responses, procedures to turn off the main gas line, phone numbers for management members, procedure for power outage, evacuation plan for a local hotel as coordinated through [LALD] or chain of command and the facility's missing resident policy. The binder included a blank Appendix Z packet. The licensee lacked the following required information according to Emergency Preparedness: Appendix Z: - establish/maintain a comprehensive emergency plan (EP) which describes the facility's approach to meeting health/safety/security needs of staff/residents addressing how they would coordinate with other, health care facilities (HCF), as well as community on a whole during emergency or disaster (natural, man-made, facility, etc.) and be reviewed/updated annually; - risk assessment which considered hazards like care related emergencies, cyber-attacks, normal supply of essential resources and medical supplies, should consider duration of interruptions, consider emerging infectious diseases (EIDs); - document risk assessment for an all hazards approach, including EIDs as applicable, categorize the various probable risks by likelihood of occurrence, develop strategies for addressing facility and community based risks (evacuation plans, staffing surges/shortages, back-up plans); - identification of at risk population needs like maintaining independence, communication, transportation, supervision, medical care; and qualified person authorized in writing to act in the	0 680			

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0 680	Continued From page 42 absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure based on the EP risk assessment and communication plan; - policy and procedure addressing whether evacuated or shelter in place for staff/residents for food, water, medical supplies, pharmaceutical supplies; - policy and procedure addressing alternate sources of energy to maintain temperatures to protect resident health/safety, safe and sanitary storage of provisions emergency lighting and sewage and waste disposal; - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure addressing safe evacuation form facility, including care and treatment needs of evacuees; staff responsibilities; primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff, and volunteers who remain in the facility; - policy and procedure addressing system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure addressing use of volunteers, including the process/role for integration; - policy and procedures addressing development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the	0 680			

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0 680	Continued From page 43 continuity of services to residents; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - develop a written communication plan; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan which includes contact information for Federal, State, tribal, regional and local EP staff; State Licensing and Certification Agency; and other sources of assistance; - communication plan which includes alternate means of communication with facility staff and Federal, State, tribal, regional and local emergency management agencies; - communication plan which includes method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4); - communication plan which includes means to providing information about the facility occupancy, needs, and it's ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; and - communication plan which includes method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; - develop and maintain an EP training and testing program; - training program which includes initial training in EP policy and procedure to all new and existing	0 680			

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0 680	Continued From page 44 staff, individuals providing services under arrangement, volunteers consistent with their expected role; provide EP training at least annually; maintain documentation of all EP training; demonstrate staff knowledge of EP; - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise. On March 8, 2023, at 1:30 p.m. DA-H stated he had just found the packet and was reviewing it. He verified the emergency preparedness binder lacked the required content and stated the information from the copy of Appendix Z was fairly clear to understand and he would work to get the required content in place. DA-H stated the current missing resident policy had likely not been reviewed every 90 days as required. DA-H stated staff have only been trained on the current content of the binder and the residents have only been involved in facility fire drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 690 SS=F	144G.43 Subdivision 1 Resident record	0 690			

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0 690	Continued From page 45 (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in the resident's records were authenticated by the name and title of the person making the entry for four of four residents (R1, R2, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 On March 7, 2023, at 8:15 a.m. unlicensed personnel (ULP)-D administered eye drops to R1. R1's medication administration record (MAR) for March 1, 2023, through March 7, 2023, included a charting legend on the last page. The legend was to include staff initials, full name, and title. The MAR identified seven staff had administered medications to R1, including ULP-D. The legend failed to identify any information for the seven staff. R1's task record dated March 1, 2023, through	0 690			

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0 690	Continued From page 46 March 7, 2023, included a charting legend on the bottom of each page. The legend was to include the name/signature and date for each staff. The task record identified seven staff had completed various tasks. The record failed to identify any information for the seven staff. R2 On March 7, 2023, at 7:16 a.m. ULP-E checked blood glucose, administered insulin, and administered oral medications to R2. R2's MAR for March 1, 2023, through March 7, 2023, included a charting legend on the last page. The legend was to include staff initials, full name, and title. The MAR identified seven staff had administered medications to R2, including ULP-D. The legend failed to identify any information for the seven staff. R2's task record dated March 1, 2023, through March 7, 2023, included a charting legend on the bottom of each of four pages. The legend was to include the name/signature and date for each staff. The task record identified seven staff had completed various tasks. The record failed to identify any information for the seven staff. R5 On March 7, 2023, at 8:30 a.m. registered nurse (RN)-B was observed to administer oral medications to R5 while in the dining area at breakfast. R5's MAR for March 1, 2023, through March 7, 2023, included a charting legend on the last page. The legend was to include staff initials, full name, and title. The MAR identified four staff had administered medications to R5, including RN-B. The legend failed to identify any information for	0 690			

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0 690	Continued From page 47 the four staff. R5's task record dated March 1, 2023, through March 7, 2023, included a charting legend on the bottom of each of four pages. The legend was to include the name/signature and date for each staff. The task record identified nine staff had completed various tasks. The record failed to identify any information for the nine staff. R6 On March 7, 2023, at 7:20 a.m. the surveyor observed unlicensed personnel (ULP)-F assist R6 with her thrombo-embolic deterrent (TED) stockings to both lower extremities, and at 7:30 a.m. the surveyor observed RN-B administer oral medications to R6 at the dining room table. R6's MAR dated February 2023, included a charting legend on the last page. The legend was to include staff initials, full name, and title. The MAR identified six staff had administered medications to R5, including RN-B. The legend failed to identify any information for the six staff. R6's task record dated March 1, 2023, through March 7, 2023, included a charting legend on the bottom of each of three pages. The legend was to include the name/signature and date for each staff. The task record identified nine staff had completed various tasks. The record failed to identify any information for the nine staff. On March 13, 2023, at 2:45 p.m. director of health care services/registered nurse (DHCS/RN)-B reviewed the task sheets and MARs for the residents above and stated there was an alternate way to view the signatures/authentication; however, the signatures/authentication was clearly not seen on	0 690			

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0 690	Continued From page 48 the records reviewed. DCS/RN-B stated she would need to clarify with the Point Click Care (PCC) support team to select the proper "box" to allow the proper view of tasks/MAR authentication for all resident records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to	0 730			

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0 730	Continued From page 49 the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document the services provided for three of four residents (R5, R1, R2) and failed to ensure the resident record included a discharge summary with the required content and provided information to the receiving facility as required for three of three discharged residents (R14, R12, R13). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 730			

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0 730	Continued From page 50 a large portion or all of the residents). The findings include: DOCUMENTATION OF SERVICES R5 R5's record lacked consistent documentation of services provided. R5's diagnoses included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, depression, and anxiety. R5's undated and unsigned Service Plan/Care Plan indicated she received services to include medication administration, bathing assistance, and every two hour checks. On March 7, 2023, at 8:30 a.m. the surveyor observed registered nurse (RN)-C to administer oral medications to R5 while she was at the dining room eating breakfast. R5's Task documentation sheet dated February 2023, indicated missing documentation of services provided on various dates/times for every two hour checks (new task started February 23, 2023, following a fall with injury/hospitalization), meal attendance, meal consumption, snacks/fluids/hydration pass, and every shift activity participation. R1 R1's diagnoses included Alzheimer's disease, syncope, major depressive disorder, insomnia, history of falls, and epilepsy. R1's undated and unsigned Service Plan/Care	0 730			

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0 730	Continued From page 51 Plan indicated R1 received services to include assistance with dressing, bathing, grooming, toileting, medication administration, and every two hour checks. On March 7, 2023, between 7:48 - 8:15 a.m. the surveyor observed unlicensed personnel (ULP)-D putting on R1's TED (thrombo-embolic deterrent) stockings (used to reduce swelling and prevent blood clots) and administer eye drops. R1's Task documentation dated February 1 2023, through February 24, 2023, indicated missing documentation of services provided on various dates/times for every two hour checks, meal attendance, snacks/fluids/hydration pass, bathing, dressing, and grooming. R2 R2's diagnoses included mild cognitive impairment and type 2 diabetes mellitus. R2's undated and unsigned Service Plan/Care Plan indicated R2 received services including housekeeping, laundry, and assistance with finances. On March 7, 2023, at 7:16 a.m. ULP-E checked blood glucose, administered insulin, and administered oral medications to R2. R2's Task documentation dated March 1 2023, through March 9, 2023, indicated missing documentation of services provided on various dates/times for safety checks every shift, meal attendance, and snacks/fluids/hydration pass. On March 13, 2023, at 2:45 p.m. director of health care services (DHCS/RN)-B confirmed the missing task documentation.	0 730			

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0 730	Continued From page 52 DISCHARGE SUMMARY R14 R14 was admitted to the facility on December 1, 2015, under the facility's comprehensive license and then on August 1, 2021, under the facility's assisted living with dementia care (ALFDC) license. R14's undated and unsigned Service Plan/Care Plan indicated R14 received services to include medication administration, shower assistance, and meal reminders. R14's progress note dated February 23, 2023, written by RN-C indicated R14 "was sent to the emergency room on February 21, 2023, for a fall. She was admitted with fracture to the left foot, she will go to [long term care facility name] after discharge from the hospital." R14's record lacked a discharge summary to include: - diagnoses; - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On March 9, 2023, at 2:05 p.m. RN-C stated after R14 was sent to the hospital and then discharged to a skilled nursing facility, a discharge summary was not completed.	0 730			

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0 730	Continued From page 53 R12 R12 was listed on the the discharge list provided by the facility with a discharge date of January 11, 2023. R12's discharge summary identified services were initiated on March 20, 2021, and services ended December 29, 2022. Reason for initiation of services was "Sent to ER [emergency room] - then son moved her to a SNF [skilled nursing facility]". Reason for discharge was "son moved her to a skilled facility". R12's progress notes lacked any documentation regarding transfer. On March 9, 2023, at 8:33 a.m. RN-C stated R12 went to the ER, was hospitalized and then moved to a skilled facility. She could not remember the date she went into the hospital and there was no documentation in the resident record regarding the transfer to the hospital. RN-C had not completed a notice of transfer when residents were sent to the hospital, nor did she provide a notice of transfer to the resident, responsible party or the ombudsman. RN-C was unaware of the requirement. R13 R13's discharge summary identified services were initiated on March 4, 2016, and was discharged on September 26, 2022. Reason for initiation of services was "needs more assistance with ADL's [activities of daily living], bathing, meals, medication, blood glucose monitoring". Reason for discharge was "went to higher level of care d/t [due to] weakness". On March 9, 2023, at 11:06 a.m. RN-C further	0 730			

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0 730	Continued From page 54 stated she had not provided a discharge summary to the residents or their representatives, she was unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to ensure installation and maintenance of portable fire extinguishers at the facility. This had potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems re pervasive	0 790			

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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
0 790	Continued From page 55 or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On March 07, 2023, from approximately 10:30 a.m. to 12:30 p.m, survey staff toured the facility with MD-I and DA-H. During the facility tour, survey staff observed that the fire extinguishers throughout the facility were not documented that monthly inspections occurred. MD-I and DA-H verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	0 810			

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NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
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0 810	Continued From page 56 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for the 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 March 07, 2023, from approximately 10:30	0 810			

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NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
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0 810	Continued From page 57 a.m. to 12:30 p.m., survey staff toured the facility with MD-I and DA-H. During the facility tour, survey staff observed that the fire evacuation plans posting throughout the facility did not show location and number of resident rooms with a clear path leading out to an exit. MD-I and DA-H verbally confirmed survey staff observations during the facility tour.. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.	0 900			

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0 900	Continued From page 58 (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of it's contract. In addition, the licensee failed to execute a written contract, after a rate change, prior to providing assisted living services for one of one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete, unsigned copy of it's contract as required. On March 7, 2023, at 11:09 a.m. licensed assisted living director (LALD)-A stated an unsigned copy of the assisted living contract was not provided to the ombudsman.	0 900			

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0 900	Continued From page 59 R2 R2's unsigned and undated, Care Plan/Service Plan indicated R2 received services including housekeeping, laundry, and assistance with finances. R2's record contained an Assisted Living Residency Agreement dated August 13, 2021, which identified R2's monthly rent and service fee. A waiver eligibility notice was in R2's file and identified R2 was eligible for waiver service starting April 14, 2022. R2's record lacked evidence a new contract was signed when R2's pay source and rate changed on April 14, 2022. On March 9, 2023, at 1:38 p.m. LALD-A stated she was unaware a new contract or amendment was required with the change in pay source and rates. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider	0 910			

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0 910	Continued From page 60 when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for four of four residents (R1, R2, R5, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R2, R5, and R6's Assisted Living Residency Agreements lacked the following required content: -the license number for the facility; -the authorized agent for the facility; and -the managing agent for the facility. R1 R1 began receiving assisted living services on August 1, 2021. R1's Assisted Living Residency Agreement dated June 15, 2021, failed to have the above noted required content. R2	0 910			

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0 910	Continued From page 61 R2 began receiving assisted living services on August 13, 2021. R2's Assisted Living Residency Agreement dated August 13, 2021, failed to have the above noted required content. R5 R5 began receiving assisted living services on August 1, 2021. R5's Assisted Living Residency Agreement dated February 12, 2021, failed to have the above noted required content. R6 R6 began receiving assisted living services on October 15, 2022. R6's Assisted Living Residency Agreement dated October 16, 2022, failed to have the above noted required content. On March 7, 2023, at 11:09 a.m. licensed assisted living director (LALD)-A confirmed the contract lacked the above required content. LALD-A verified the licensee contract would lack the same for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility	0 920			

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0 920	Continued From page 62 is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for four of four residents (R1, R2, R5, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 920			

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0 920	Continued From page 63 The findings include: R1, R2, R5, and R6's Assisted Living Residency Agreements lacked the following required content: -disclosure of the category of assisted living facility license held by the facility (including dementia care); -a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; and -disclosure of the facilities ability to provide specialized diets. R1 R1 began receiving assisted living services on August 1, 2021. R1's Assisted Living Residency Agreement dated June 15, 2021, failed to have the above noted required content. R2 R2 began receiving assisted living services on August 13, 2021. R2's Assisted Living Residency Agreement dated August 13, 2021, failed to have the above noted required content. R5 R5 began receiving assisted living services on August 1, 2021. R5's Assisted Living Residency Agreement dated February 12, 2021, failed to have the above noted required content. R6 R6 began receiving assisted living services on	0 920			

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0 920	Continued From page 64 October 15, 2022. R6's Assisted Living Residency Agreement dated October 16, 2022, failed to have the above noted required content. On March 7, 2023, at 11:09 a.m. licensed assisted living director (LALD)-A confirmed the contract lacked the above required content. LALD-A verified the licensee contract would lack the same for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920			
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;	0 930			

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0 930	Continued From page 65 (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for four of four residents (R1, R2, R5, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R2, R5, and R6's Assisted Living Residency Agreements lacked the following required content: - the right to appeal the termination of an assisted living contract; and - the facility's policy regarding transfer of residents within the facility under what circumstances a transfer may occur, and the circumstances under which the resident consent is required for a transfer. R1 R1 began receiving assisted living services on August 1, 2021. R1's Assisted Living Residency Agreement dated June 15, 2021, failed to have the above noted required content.	0 930			

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0 930	Continued From page 66 R2 R2 began receiving assisted living services on August 13, 2021. R2's Assisted Living Residency Agreement dated August 13, 2021, failed to have the above noted required content. R5 R5 began receiving assisted living services on August 1, 2021. R5's Assisted Living Residency Agreement dated February 12, 2021, failed to have the above noted required content. R6 R6 began receiving assisted living services on October 15, 2022. R6's Assisted Living Residency Agreement dated October 16, 2022, failed to have the above noted required content. On March 7, 2023, at 11:09 a.m. licensed assisted living director (LALD)-A confirmed the contract lacked the above required content. LALD-A verified the licensee contract would lack the same for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930			
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S	0 940			

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0 940	Continued From page 67 and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for four of four residents (R1,	0 940			

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0 940	Continued From page 68 R2, R5, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R2, R5, and R6's Assisted Living Residency Agreements lacked the following required content: - a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: - whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that medical assistance waivers provide payment for services, but do not cover	0 940			

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0 940	Continued From page 69 the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; - the contact information to obtain long-term care consulting services under section 256B.0911; and - the toll-free phone number for the Minnesota Adult Abuse Reporting Center. R1 R1 began receiving assisted living services on August 1, 2021. R1's Assisted Living Residency Agreement dated June 15, 2021, failed to have the above noted required content. R2 R2 began receiving assisted living services on August 13, 2021. R2's Assisted Living Residency Agreement dated August 13, 2021, failed to have the above noted required content. R5 R5 began receiving assisted living services on August 1, 2021. R5's Assisted Living Residency Agreement dated February 12, 2021, failed to have the above noted required content. R6 R6 began receiving assisted living services on October 15, 2022.	0 940			

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NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
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0 940	Continued From page 70 R6's Assisted Living Residency Agreement dated October 16, 2022, failed to have the above noted required content. On March 7, 2023, at 11:09 a.m. licensed assisted living director (LALD)-A confirmed the contract lacked the above required content. LALD-A verified the licensee contract would lack the same for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."	0 950			

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0 950	Continued From page 71 (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to designated representative on a document separate from the contract and failed to ensure the contract included required content for four of four residents (R1, R2, R5, and R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R2, R5, and R6's records lacked the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated	0 950			

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0 950	Continued From page 72 Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." The contract lacked a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. R1's Assisted Living Residency Agreement was dated June 15, 2021. R1's record failed to have the above noted required content. R2's Assisted Living Residency Agreement was dated August 13, 2021. R2's record failed to have the above noted required content. R5's Assisted Living Residency Agreement was dated February 12, 2021. R5's record failed to have the above noted required content. R6's Assisted Living Residency Agreement was dated October 16, 2022. R6's record failed to have the above noted required content. On March 7, 2023, at 11:09 a.m. licensed assisted living director (LALD)-A stated the right to designate a representative notice was not given to any of the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			

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0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for four of four residents (R1, R2, R5, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R2, R5, and R6's Assisted Living Residency Agreements all contained the following clause: "INDEMNITY: Resident agrees not to make claims against Alternative Continuum of Care and not to hold Alternative Continuum of Care responsible for any harm or injury to Resident, or the Resident's guests, unless caused by Alternative Continuum of Care's negligence.	0 970			

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0 970	Continued From page 74 Resident agrees to hold Alternative Continuum of Care harmless and pay any damages resulting in any bodily injury or property damages caused by the Resident's ordinary (or greater) negligence or the ordinary (or greater) negligence of the Resident's guests. Alternative Continuum of Care recommends that Resident obtain renter's insurance to protect against personal liability or personal property damage." R1 R1 began receiving assisted living services on August 1, 2021. R1's Assisted Living Residency Agreement dated June 15, 2021, had the above noted indemnity clause. R2 R2 began receiving assisted living services on August 13, 2021. R2's Assisted Living Residency Agreement dated August 13, 2021, had the above noted indemnity clause. R5 R5 began receiving assisted living services on August 1, 2021. R5's Assisted Living Residency Agreement dated February 12, 2021, had the above noted indemnity clause. R6 R6 began receiving assisted living services on October 15, 2022. R6's Assisted Living Residency Agreement dated October 16, 2022, had the above noted indemnity	0 970			

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0 970	Continued From page 75 clause. On March 7, 2023, at 11:09 a.m. licensed assisted living director (LALD)-A stated all the contracts were the same so they all would have the waiver of liability. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=F	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. (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 and the Office of Ombudsman for Mental Health and Developmental Disabilities; (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	01060			

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01060	Continued From page 76 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.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation when the residents did not return to the facility after four days, for two of two residents (R14, R12). 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:	01060			

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01060	Continued From page 77 R14 R14 was admitted to the facility on December 1, 2015, under the facility's comprehensive license and then on August 1, 2021, under the facility's assisted living with dementia care (ALFDC) license. R14's unsigned and undated, Service Plan/Care Plan indicated R14 received services including medication administration, shower assistance, and meal reminders. R14's progress note dated February 23, 2023, written by registered nurse (RN)-C indicated R14 "was sent to the emergency room on February 21, 2023, for a fall. She was admitted with fracture to the left foot, she will go to [long term care facility name] after discharge from the hospital." R14's record lacked 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; - 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. On March 9, 2023, at 2:05 p.m. RN-C stated after	01060			

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01060	Continued From page 78 R14 was sent to the hospital and then discharged to a skilled nursing facility, the written notice and notification to the Office of Ombudsman for Long-Term Care were not completed as required. R12 R12 was on the the discharge resident list provided by the facility with a move out date of January 11, 2023. R12's discharge summary identified services were initiated on March 20, 2021, and services ended December 29, 2022. Reason for initiation of services was "Sent to ER [emergency room] - then son moved her to a SNF [skilled nursing facility]". Reason for discharge was "son moved her to a skilled facility". R12's progress notes lacked any documentation regarding the transfer. On March 9, 2023, at 8:33 a.m. RN-C stated R12 went to the ER, was hospitalized and then moved to a skilled facility. She could not remember the date she went into the hospital, and there was no documentation in the chart regarding the transfer to the hospital. RN-C had not completed a notice of transfer when residents were sent to the hospital, nor did she provide a notice of transfer to the resident, responsible party or the ombudsman because RN-C was unaware of the requirement. At 11:06 a.m., RN-C further stated she had not provided a discharge summary to the resident or their representative because she was unaware of the requirement. R12's record lacked 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	01060			

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01060	Continued From page 79 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; - 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			
01290 SS=H	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced	01290			

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01290	Continued From page 80 by: Based on observation, interview and record review, the licensee failed to ensure a background study was completed and cleared prior to staff providing services for two of six employees (unlicensed personnel (ULP)-D and ULP-F). This had the potential to affect all residents. This resulted in an immediate correction order on March 7, 2023, at 2:00 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a 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-D began providing cares under the Comprehensive license on May 24, 2021, and began providing services under the Assisted Living with Dementia Care license on August 1, 2021. On March 7, 2023, ULP-D was observed completing the following tasks independently: - at 7:21 a.m. ULP-D checked blood glucose, administered oral medications, and administered insulin to R7; - at 7:48 a.m. ULP-D applied TED (thrombo-embolic deterrent) stockings (compression stockings used to increase circulation and decrease swelling) to R1; and - at 8:15 a.m. ULP-D administered eye drops to R1.	01290			

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01290	Continued From page 81 ULP-F ULP-F began providing cares under the Comprehensive Home Care license on February 18, 2010, and began providing services under the Assisted Living with Dementia Care license on August 1, 2021. On March 7, 2023, at 7:20 a.m. the surveyor observed ULP-F independently assist R6 with placement of TED stockings to bilateral lower extremities, and then assisted R6 to the bathroom. According to Department of Human Services NETStudy for background studies, ULP-D and ULP-F were not cleared to provide direct care services to residents without direct supervision. On March 7, 2023, at 2:00 p.m. licensed assisted living director (LALD)-A stated she was in charge of completing the background studies. LALD-A logged into NETstudy and confirmed ULP-D and ULP-F were not listed as having a current background study completed. She was unsure why they were not in the system. LALD-A further stated if ULP-D and ULP-F did not have current background studies, there was probably more staff that did not have it completed. The licensee's undated, Screening of Home Care Job Applicants policy identified "All job applicants will be screened to assure compliance with applicable state laws and our agency's requirements, including background checks. No new employee will have unsupervised direct contact with clients until all required screenings have been satisfactorily completed and any applicable licenses, registrations or certifications	01290			

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01290	Continued From page 82 have been verified." "Once the applicants references have been checked and the background check has been completed and the applicant is not disqualified, the Director of Housing may extend an offer of employment" No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On March 8, 2023, at 2:56 p.m. the immediacy was removed based on observations by the surveyor and record reviews by evaluation supervisor; however, non-compliance remains at a scope and level of H. TIME PERIOD FOR CORRECTION: Two (2) Days	01290			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting;	01370			

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01370	Continued From page 83 (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-D) completed training and competency evaluations in all required training topics. 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:	01370			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30707	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/13/2023
NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01370	Continued From page 84 ULP-D was hired on May 24, 2021, to provide direct care and services to the licensee's residents under the comprehensive home care license. ULP-D began providing direct care and services under the assisted living licensure on August 1, 2021. On March 7, 2023, ULP-D was observed completing the following tasks independently: - at 7:21 a.m., ULP-D checked blood glucose, administered oral medications, and administered insulin to R7; - at 7:48 a.m., ULP-D applied TED (thrombo-embolic deterrent) stockings (compression stockings used to increase circulation and decrease swelling) to R1; and - at 8:15 a.m., ULP-D administered eye drops to R1. ULP-D's employee record lacked evidence of completed training and/or competency for the following: - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; and - communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family. On March 8, 2023, at 1:33 p.m. director of health care services/registered nurse (DHCS/RN)-B stated the training should be in the employee files and if it is not there then it was not done. On March 8, 2023, at 3:40 p.m. RN-C stated the facility used to have staff, upon hire, complete a medication class with training by a RN until the	01370			

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NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01370	Continued From page 85 previous director of health services left her position two years ago. Since that time, they have not had a medication class, and there was no training for medication administration by the RN prior to new employees completing those tasks. RN-C did training upon hire but was unaware of the missing content. The licensee's undated, Training and Competency Evaluation of Unlicensed Staff policy identified "Unlicensed home care personnel will meet all orientation and training requirements and will be determined to be competent to perform all assigned tasks by the RN or by other Licensed Health Professional, when appropriate, before unlicensed personnel may provide any service to a home care client." Training and competency would be completed for the following: - Standby assistance techniques and how to perform them (practical skills test required); - Medication, exercise and treatment reminders (written or oral test required); and - Communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family (written or oral test required). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:	01380			

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01380	Continued From page 86 (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-D and ULP-E) completed training and competency evaluations in all required training topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on May 24, 2021, to provide direct care and services to the licensee's residents under the comprehensive home care license and on August 1, 2021, under the assisted living licensure.	01380			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30707	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/13/2023
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01380	Continued From page 87 On March 7, 2023, ULP-D was observed completing the following tasks independently: - at 7:21 a.m., ULP-D checked blood glucose, administered oral medications, and administered insulin to R7; - at 7:48 a.m., ULP-D applied TED (thrombo-embolic deterrent) stockings (compression stockings used to increase circulation and decrease swelling) to R1; and - at 8:15 a.m., ULP-D administered eye drops to R1. ULP-D's employee record lacked evidence of completed training and/or competency for the following: - recognizing physical, emotional, cognitive, and developmental needs of the client. ULP-E ULP-E began providing services under the ALFDC license on December 30, 2022. On March 7, 2023, ULP-E was observed completing the following tasks: - at 6:50 a.m., ULP-E checked blood glucose, administered oral medications, and administered insulin to R3; - at 7:02 a.m., ULP-E administered oral medications to R11; and - at 7:16 a.m., ULP-E checked blood glucose, administered insulin, and administered oral medications to R2. ULP-E's employee record lacked evidence of completed competency for the following: - administering medications or treatments. On March 8, 2023, at 1:33 p.m. director of health	01380			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30707	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/13/2023
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01380	Continued From page 88 care services/registered nurse (DHCS/RN)-B stated the training should be in the employee files and if it is not there then it was not done. On March 8, 2023, at 3:40 p.m. RN-C stated the facility used to have staff complete a medication class with training by a RN until the previous director of health services left her position two years ago. Since that time, they have not had a medication class, and there was no training for medication administration by the RN prior to new employees completing those tasks. RN-C did training upon hire but was unaware of the missing content. The licensee's undated, Training and Competency Evaluation of Unlicensed Staff policy identified "Unlicensed home care personnel will meet all orientation and training requirements and will be determined to be competent to perform all assigned tasks by the RN or by other Licensed Health Professional, when appropriate, before unlicensed personnel may provide any service to a home care client." Training and competency would be completed for the following: - recognizing physical, emotional, cognitive, and developmental needs of the client; and - administering medications or treatments as required (practical skills test required). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics:	01470			

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01470	Continued From page 89 (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 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:	01470			

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01470	Continued From page 90 (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 three of three employees (director of health care services/registered nurse (DHCS/RN)-B, unlicensed personnel (ULP)-D, ULP-E) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: DHCS/RN-B was hired on October 3, 2022, and began providing assisted living with dementia	01470			

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01470	Continued From page 91 care services. Throughout the survey on March 6-13, 2023, DHCS/RN-B was observed to interact with multiple residents and licensee staff. DHCS/RN-B's record lacked evidence of receiving orientation to assisted living with dementia care to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -assisted living bill of rights (reviewed were home-care bill of rights dated 2019); - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and -principles of person-centered planning/service delivery. On March 10, 2023, at 1:00 p.m. DHCS/RN-B stated she received some initial training at the corporate office in Wisconsin but has not received much training since that time. ULP-D ULP-D was hired on May 24, 2021, to provide direct care and services to the licensee's residents under the comprehensive home care license and on August 1, 2021, under the assisted living licensure. On March 7, 2023, ULP-D was observed completing the following tasks independently: - at 7:21 a.m., ULP-D checked blood glucose, administered oral medications, and administered insulin to R7; - at 7:48 a.m., ULP-D applied TED	01470			

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01470	Continued From page 92 (thrombo-embolic deterrent) stockings (compression stockings used to increase circulation and decrease swelling) to R1; and - at 8:15 a.m., ULP-D administered eye drops to R1. ULP-D's record lacked evidence of receiving orientation to assisted living with dementia care to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -assisted living bill of rights (reviewed were home-care bill of rights dated 2019); - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and -principles of person-centered planning/service delivery. ULP-E ULP-E began providing services under the ALFDC license on December 30, 2022. On March 7, 2023, ULP-E was observed completing the following tasks: - at 6:50 a.m., ULP-E checked blood glucose, administered oral medications, and administered insulin to R3; - at 7:02 a.m., ULP-E administered oral medications to R11; and - at 7:16 a.m., ULP-E checked blood glucose, administered insulin, and administered oral medications to R2. ULP-E's record lacked evidence of receiving orientation to assisted living with dementia care to	01470			

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01470	Continued From page 93 include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -assisted living bill of rights (reviewed were home-care bill of rights dated 2019); - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and -principles of person-centered planning/service delivery. On March 8, 2023, at 1:33 p.m. DHCS/RN-B stated the training should be in the employee files and if it is not there, then it was not done. On March 8, 2023, at 3:40 p.m. RN-C stated she did training upon hire but was unaware of the missing content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470			
01500 SS=D	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	01500			

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01500	Continued From page 94 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 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	01500			

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01500	Continued From page 95 (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 included all required topics for each 12 months of employment for two of three employees (registered nurse (RN)-C and unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-C RN-C was hired on July 22, 2003, and had provided direct care services under the licensee's assisted living with dementia care license since August 1, 2021. On March 7, 2023, at 8:30 a.m. RN-C was observed to administer oral medications to R5 in the dining room of the memory care unit. RN-C's employee training record indicated	01500			

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01500	Continued From page 96 December 29, 2019, as the last date she had received/completed any training; RN-C lacked the required eight hours of annual training, and lacked the required annual training content to include: -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 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-D was hired on May 24, 2021, to provide direct care and services to the licensee's residents under the comprehensive home care license and on August 1, 2021, under the assisted living licensure. On March 7, 2023, ULP-D was observed completing the following tasks independently:	01500			

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NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
(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 97 - at 7:21 a.m. ULP-D checked blood glucose, administered oral medications, and administered insulin to R7; - at 7:48 a.m. ULP-D applied TED (thrombo-embolic deterrent) stockings (compression stockings used to increase circulation and decrease swelling) to R1; and - at 8:15 a.m. ULP-D administered eye drops to R1. ULP-D's employee file lacked the required eight hours of annual training, and lacked the required annual training content to include: -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 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.	01500			

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01500	Continued From page 98 On March 8, 2023, at 1:33 p.m. director of health care services/registered nurse (DHCS/RN)-B stated the training should be in the employee files and if it is not there then it was not done. The licensee's undated, Annual In-Service training policy indicated all staff that performs direct home care services, including licensed staff, must complete at least eight hours of annual training for each 12 months of employment. 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;	01540			

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01540	Continued From page 99 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure four of four employees (director of health care services/registered nurse (DHCS/RN)-B, RN-C, unlicensed personnel (ULP)-D, ULP-E) completed the required amount of dementia care training in the required time frame. 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: The licensee had an Assisted Living with Dementia Care license dated August 1, 2022. DHCS/RN-B DHCS/RN-B was hired on October 3, 2022, and began providing assisted living with dementia care services. Throughout the survey process on March 6-13, 2023, DHCS/RN-B was observed to interact with multiple residents and licensee staff. DHCS/RN-B's employee record lacked evidence of completing eight hours of dementia training within 80 hours of the employee's start date. DHCS/RN-B's record lacked evidence of any	01540			

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01540	Continued From page 100 dementia training. On March 10, 2023, at 1:00 p.m. DHCS/RN-B stated she received some initial training at the corporate office in Wisconsin but has not received much training since that time, and has only received approximately one hour of dementia training. RN-C RN-C was hired on July 22, 2003, under the licensee's comprehensive home care license, and on August 1, 2021, began providing services under the licensee's assisted living with dementia care license. On March 7, 2023, at 8:30 a.m. RN-C was observed to administer oral medications to R5 in the dining room of the memory care unit. RN-C's employee record indicated dementia training with a total of 5.25 annual hours was last completed on December 29, 2019. The licensee failed to ensure RN-C completed the minimum annual requirement of two hours of dementia training. ULP-D ULP-D was hired on May 24, 2021, to provide direct care and services to the licensee's residents under the comprehensive home care license and on August 1, 2021, under the assisted living licensure. On March 7, 2023, ULP-D was observed completing the following tasks independently: - at 7:21 a.m., ULP-D checked blood glucose, administered oral medications, and administered insulin to R7; - at 7:48 a.m., ULP-D applied TED (thrombo-embolic deterrent) stockings	01540			

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01540	Continued From page 101 (compression stockings used to increase circulation and decrease swelling) to R1; and - at 8:15 a.m., ULP-D administered eye drops to R1. ULP-D's employee record lacked evidence of completing a total of eight hours of dementia training within 80 hours of the employee's start date. ULP-D's record lacked evidence of any dementia training. ULP-E ULP-E began providing services under the ALFDC license on December 30, 2022. On March 7, 2023, ULP-E was observed completing the following tasks: - at 6:50 a.m., ULP-E checked blood glucose, administered oral medications, and administered insulin to R3; - at 7:02 a.m., ULP-E administered oral medications to R11; and - at 7:16 a.m., ULP-E checked blood glucose, administered insulin, and administered oral medications to R2. ULP-E's employee record did not indicate a total of eight hours of the required dementia training was completed within 80 hours of the employee's start date. ULP-D's record lacked evidence of any dementia training. On March 8, 2023, at 1:33 p.m. DHCS/RN-B stated the training should be in the employee files and if it is not there, then it was not done. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01540			

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01540	Continued From page 102 (21) days	01540			
01620 SS=I	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a comprehensive assessment with a change of condition, not to exceed 90 days, resulting in the potential for harm for two of two residents (R1, R5). This had the potential to affect all residents residing in the facility and resulted in an	01620			

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01620	Continued From page 103 immediate correction order on March 10, 2023, at 9:08 a.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the facility under the comprehensive license on June 15, 2021, and later the assisted living with dementia care (ALFDC) license on August 1, 2021. On March 7, 2023, between 7:48 - 8:15 a.m. the evaluator observed unlicensed personnel (ULP)-D putting TED (thrombo-embolic deterrent) stockings (used to reduce swelling and prevent blood clots) on and administer eye drops to R1, who resided in the non-secured area of the building. R1's diagnosis included Alzheimer's disease, epilepsy, major depressive disorder, syncope and history of falls. R1's care plan (identified as the service plan) undated and unsigned, indicated R1 received assistance with bathing, medication administration, ace wrap placement, dressing, grooming, toileting, and bathing. The plan identified R1 had a "deficit in transferring related to weakness" last revised on June 16, 2021. The goal identified he was to "transfer with one to two	01620			

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01620	Continued From page 104 staff assist with the use of a sit to stand lift" last revised on December 12, 2022. The care plan's intervention for R1 included staff were to "provide step by step guidance during the transfer process, encouraging participation as much as possible." R1 worked with physical therapy and was able to transfer on and off the toilet with verbal cues using the grab bar in the bathroom initiated on March 6, 2022. It further identified that R1 was at risk of falls related to dementia last revised on June 28, 2021. The goal identified R1's risk for falls would be minimized; last revised on December 12, 2022. Interventions included: staff were to become familiar with the resident's daily routine and attempt to anticipate and meet the residents needs daily, encourage participation in activities that will increase strength and mobility, remind resident to use assistive devices - wheelchair and to wait for assist, and remind resident to use pull cord in the bathroom for assistance as needed; last revised June 16, 2021. R1's progress notes dated December 17, 2022, identified R1 went to the emergency room for evaluation, had orders for Tylenol and ibuprofen, and could use "Norco" (narcotic pain medication) for pain if Tylenol and ibuprofen were not enough. R1 received orders to use heat and ice to the affected area and to wear the sling except when showering and bathing. He was to follow up with his primary physician and orthopedics. The note did not identify how R1 was injured or what the injury was. R1's incident report dated December 17, 2022, identified "while staff was transferring [R1] from the toilet to the wheelchair he forcefully sat down and both of his arms were still up in the easy stand, and the resident fell down in between the	01620			

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01620	Continued From page 105 bathroom and the living room. He landed on his bottom, head and feet were flat. The resident was wearing a red t-shirt with blue jeans and glasses, and had his black slip-on shoes on." Resident Description: [R1] stated he felt really weak and tired and he couldn't stand while in the easy stand; he sat down while still in the machine. R1's level of pain was a 6. "No Injuries Observed Post Incident." The report had a section for mental status that was not completed. A section titled Predisposing Environmental Factors identified: none. Predisposing Physiological Factors identified: weakness. Predisposing Situational Factors identified: during transfer. The documentation was not completed for notifications to family, physician, and agencies. The record lacked evidence an investigation was completed as to the cause of the fall, a comprehensive assessment had been completed, or that interventions were put into place to prevent further falls. An After Visit Summary dated December 17, 2022, unsigned, from the emergency department identified R1 had a fracture of the clavicle. R1 had orders for Tylenol and ibuprofen and could use "Norco" (narcotic pain medication) for pain if Tylenol and ibuprofen were not enough. R1 received orders to use heat and ice to the affected area and was to wear the sling except when showering and bathing. He was to follow up with his primary physician and orthopedics. R1's record identified the last comprehensive assessment completed by a registered nurse (RN) was dated August 8, 2021. It identified R1 resided in the (secured) memory care unit. The assessment contained the following statements: - Resident is continent of both bowel and bladder and receives no toileting assistance	01620			

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01620	Continued From page 106 - Incontinence - TRANSFER: The resident requires assistance with transfers. - The resident has bladder incontinence r/t: - The resident will have fewer episodes of urinary incontinence managed by prompt response time to pendant and regular toileting. Urinal at bedside at HS. - BRIEF USE: Depends disposable briefs. Toilet often and change as needed. - The resident has bowel incontinence r/t: - The resident will be continent during daytime - Intervention: Assist resident with bathroom promptly when calling for assistance (pendant) Offer toileting at regular intervals to prevent urgency and allow resident adequate time to toilet - Staff to provide full assistance with incontinence care. - BATHROOM ASSISTANCE: Encourage resident to participate as much as possible to promote independence. The resident needs assistance from 1-2 staff for toilet use. Offer urinal at night - Mobility needs - Resident needs assistance of one person for transfers - Resident will be able to transfer with one to two assist and gait belt. - transfers - resident does not require an assertive device - Resident needs full assistance of 1-2 care staff for mobility - Falls - The resident is at risk for falls r/t dementia - goal- The resident's fall risk will be minimized - Interventions: become familiar with the resident's daily routine and attempt to anticipate	01620			

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01620	Continued From page 107 and meet the resident's needs daily, encourage participation in activities that will increase strength and mobility, remind resident to use assistive devices -wheelchair and to wait for assist, and remind resident to use call device pendant/pull cord IN THE BATHROOM for assistance as needed. R1's record identified ongoing Monitoring and Reassessments were completed on October 3, 2021, December 15, 2021, March 9, 2022, June 2, 2022, September 3, 2022, December 10, 2022, and March 4, 2023; however, these were not comprehensive assessments. R1's Morse Fall MN assessment completed on December 17, 2022, identified he was at high risk for falls. On March 10, 2023, at 7:04 a.m. director of health care services/registered nurse (DHCS/RN)-B stated a fall with injury would have been a significant change in condition and R1 should have had a comprehensive assessment completed. DHCS/RN-B also stated the Monitoring and Reassessment was not a comprehensive assessment. She believed R1 moved from (secured) memory care unit to the (non-secured) assisted living unit approximately one year ago. R1's task documentation record for March 1, 2023, through March 8, 2023, identified the following: - Transfer: the resident requires assistance with transfers with use of sit to stand lift assist of 1-2 staff to be completed every shift and as needed. Documentation with initials included was completed as follows: March 1, 2023, at 4:29 a.m. and 7:49 p.m.	01620			

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01620	Continued From page 108 March 2, 2023, at 12:00 a.m. and 1:59 p.m. March 3, 2023, at 4:16 a.m., 1:59 p.m., and 8:08 p.m. March 4, 2023, at 10:18 a.m. and 9:04 p.m. March 5, 2023, at 10:23 a.m. and 8:18 p.m. March 6, 2023, at 1:34 a.m. and 10:46 a.m. March 7, 2023, at 3:45 a.m. and 1:25 p.m. March 8, 2023, at 5:19 a.m., 1:59 p.m., and 6:25 p.m. - "Safety checks every two hours as he was moved to the assisted side" March 1, 2023: at 4:28 a.m., 4:28 a.m., 4:29 a.m., 7:48 p.m., 7:48 p.m., 7:48 p.m., 7:49 p.m. and 11:59 p.m. March 2, 2023: at 11:59 p.m., 1:53 a.m., 3:54 a.m., 10:37 a.m., 10:37 a.m., 10:37 a.m., 12:00 p.m., and 4:16 a.m. March 3, 2023: at 4:16 a.m., 4:16 a.m., 4:16 a.m., 11:14 a.m., 11:16 a.m. 11:16 a.m., 11:16 a.m., 8:07 p.m., 8:07 p.m., 8:07 p.m., and 2:51 a.m. March 4, 2023: 2:51 a.m., 2:51 a.m., at 10:17 a.m., 10:17 a.m., 10:18 a.m., 11:07 a.m., 9:03 p.m., 9:03 p.m., 9:04 p.m., and 9:04 p.m. March 5, 2023: at 10:22 a.m., 10:22 a.m., 10:23 a.m., 12:00 p.m., 8:17 p.m., 8:17 p.m., 8:18 p.m., 8:18 p.m., and 11:59 p.m. March 6, 2023: at 11:59 p.m., 1:33 a.m., 1:33 a.m., 10:44 a.m., 10:44 a.m., 10:46 a.m., 1:31 p.m., and 3:45 a.m. March 7, 2023: at 3:44 a.m., 3:44 a.m., 3:45 a.m., 1:25 p.m., 1:25 p.m., 1:25 p.m., 1:25 p.m., and 11:53 p.m. March 8, 2023: at 11:53 p.m., 1:07 a.m., 5:19 a.m., 6:00 a.m., 8:00 a.m., 10:00 a.m., 12:00 p.m., 6:24 p.m., 6:24 p.m., 6:24 p.m., 9:41 p.m., and 12:55 a.m. On March 10, 2023, at 9:45 a.m. ULP-J and ULP-K stated they were no longer using the sit to stand lift for R1. Staff were using it but it "stopped	01620			

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01620	Continued From page 109 a couple weeks ago." Currently they are directing him to use grab bars and guiding him with transfers, and that was what they did this morning. They were unaware who was responsible for making the decisions of how residents were transferred. If they had concerns regarding transfers, they would tell the shift care manager (ULP) or the licensed assisted living director (LALD). On March 10, 2023, at 10:14 a.m. ULP-D stated currently R1 transfers by using the grab bars and she has her hand on him for support and guidance only. Prior to the fall, R1 was transferred by using the grab bars and staff assist, but he was having problems with pain in his legs and needed more assist, so they were using the sit to stand lift. After the fall, he was using the sit to stand lift as well, but he went to therapy and had improved back to transfers with the grab bar and one assist. If she had concerns with how someone was transferring, she would notify one of the nurses. R1 was not able to be interviewed. R5 R5 began receiving services under the licensee's comprehensive license on December 15, 2015, and later under the licensee's assisted living with dementia care license since August 1, 2021. R5's diagnoses included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, depression, and anxiety. R5's unsigned Service Plan/Care plan indicated she received services to include medication	01620			

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01620	Continued From page 110 administration, bathing assistance, and every two-hour checks. On March 7, 2023, at 7:20 a.m., R5 was observed leaving her apartment in the (secured) memory care unit when ULP-F assisted with getting R5's walker and then reminded R5 to use her walker. R5 responded, "That's right, I don't want to fall again and bang my head and get those things [staples] put in my head again." Additionally, at 8:30 a.m. the surveyor observed RN-C to administer oral medications to R5 while she was at the dining room eating breakfast. FALLS R5's record lacked a comprehensive assessment following two subsequent falls (one with injury). R5's record included the following fall reports: -February 22, 2023, indicated an "un-witnessed fall in the resident's room. The staff found resident on one knee in the hallway outside her room-blood on two areas on the back of her head. Resident stated she fell straight back and hit her head. Immediate action taken-cleaned up the blood, R5 is alert and oriented but complained her head hurt so sent her to the ER to be evaluated." -February 24, 2023, indicated an "unwitnessed fall, resident was found on the floor by another resident. Staff heard another resident yelling for help. Staff went and found the resident laying on her floor by the end of the bed with a bag of candy. She as lying on her left side on top of her left arm and left side. Resident said she fell out of bed, but the bed was untouched. She was then stating that her left hip and left shoulder hurt really bad. Staff called 911 for help. Vital signs were taken by the EMT [Emergency Medical Technician]. Resident was taken to the hospital."	01620			

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01620	Continued From page 111 R5's Nurse Progress notes included: -February 22, 2023, at 10:26 p.m.- Sent to ER after fall. ER just called to report she would be staying for observation tonight as her Troponin levels (a heart enzyme level) had elevated-notified (resident representative). -February 23, 2023, at 10:06 a.m.-communication with physician (as copied from the After Visit Summary sent by the hospital/ER)- "Seen in ER by (physician's name)- ok to return home-ok to resume your usual home medications-diet-activities-you do have a bladder infection noted on today's labs-you received IV medication Rocephin while in the ED-you will continue to take Keflex 500 mg (milligrams) PO (orally) daily for 4 (four) days start Thursday-you did receive Diflucan (an oral medication) for yeast in the urine today as well-nothing more needs to be done at this time-you are a bit dehydrated today as well-you did receive IV (intravenous) fluids while in the ED today-Increase fluids-I do want you to see your PCP (primary care provider) in the next 5 (five) days for reevaluation of labs and staple removal. For the fluttering I have requested outpatient heart monitor for 7 (seven) days the clinic will call for appointment date and time to place the monitor-scalp laceration there are 7 staples in the scalp which need to be removed in 5 days-ok to shower and rinse hair-pat dry-Increase metoprolol to 37.5 mg twice daily." -February 26, 2023, at 6:24 p.m.-communication with physician- (as copied from the After Visit Summary from the ER), "Seen in ER for a fall February 24, 2022. Rest and stay well hydrated. Take 650-1000 mg of Tylenol every 8 (eight) hours as needed for pain control-continue taking your antibiotic for urinary tract infection as previously directed-follow up with PCP within a week to further assess today's incidental finding	01620			

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01620	Continued From page 112 (new short segment of circumferential mural thickening and luminal narrowing involving the transverse colon over a length of 1.6 cm)-return to ED if you develop worsening symptoms." R5's Service Plan/Care Plan (undated) indicated a focus area initiated/updated on February 23, 2023, indicated all staff to monitor that the resident is wearing appropriate footwear or non-skid socks when ambulating or mobilizing in w/c (wheelchair). Assess/observe regularly for a safe environment with even floors free from spills and/or clutter' adequate, glare-free light, and personal items within reach. Resident had fall: placed on 2-hour checks. R5's record included a Morse Fall MN-V3 document dated February 26, 2023, as completed by RN-C. The licensee failed to complete a comprehensive assessment upon R5's return after an overnight stay and the hospital and return trip to the ER, to include an assessment and measurements of the scalp wound, presence of scalp staples and known urinary tract infection with the treatment of antibiotics. On March 9, 2023, at 2:45 p.m. RN-C stated after R5's return from the hospital on February 23, 2023, and then following R5's return to the facility from an ER visit later that day, she did not complete a full comprehensive assessment. RN-C stated, "I completed the Fall Assessment tool (Morse Fall) and Pain assessment tool, as that is our process. I did not complete a full comprehensive assessment. I put every two-hour safety checks in place that started on February 23, 2023, and updated R5's Service Plan/Care Plan. RN-C stated she verbally told the ULP about caring for R5 and thought she had written information on a shift report sheet, but was	01620			

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01620	Continued From page 113 unable to locate it. ASSESSMENTS R5's record indicated the last comprehensive assessment was completed on February 26, 2021. R5's record indicated the licensee completed the Monitoring and Reassessment (which is an abbreviated assessment tool used by the licensee through PCC (Point Click Care) on the following dates: -May 27, 2021 -August 26, 2021 -November 25, 2021 -February 22, 2022 -May 28, 2022 -August 24, 2022; and -November 24, 2022. R5's comprehensive assessment and Monitoring and Reassessments as listed above each indicated R5 was "independent with ambulation" and in "5. assistive devices" d. "none" was selected. The Monitoring and Reassessments lacked the required content of a comprehensive assessment and failed to accurately indicate R5's use of an assistive device (walker). On March 9, 2023, at 11:20 a.m. RN-C stated she had not been completing a full comprehensive assessment every 90 days, nor with a change in condition. RN-C stated she used the tool in PCC (Point Click Care, the facility's electronic documentation tool) and selected the 90-day tool, which is an abbreviated version of the assessment she understood to use. RN-C stated she usually completed a full comprehensive assessment on an annual basis but had likely	01620			

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01620	Continued From page 114 missed doing this on many residents across the facility. On March 10, 2023, at 10:10 a.m. ULP-L stated, "[R5] has had her walker for a long time and uses it on and off but is not consistent. She has used it more consistently since her recent falls." The licensee's policy titled, Initial and On-Going Nursing Assessment of Clients, undated, identified, "An RN will complete a nursing assessment of each Comprehensive home care client within five days of the initiation of home care services, and prior to the initiation of nursing or delegated nursing services or therapy or assigned therapy services. The assessment will be the basis for the service plan that the RN will recommend to the client and the basis for the care plan that staff will follow when implementing the client's services. The RN will reassess the client and update the service plan based on the client's needs and at a frequency not to exceed 90 days from the last date of the assessment. The RN will review the nursing assessment and service plan and, if necessary, will update the assessment and service plan, whenever the client has returned from a hospital or nursing home stay, has a change in condition or experiences an incident such as a fall." "On-Going Assessments of Clients. The RN will re-assess each client on an on-going basis and will revise the client's service plan based on the client's needs. The RN will determine the frequency of re-assessments based on the client's needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. The RN may delegate the responsibility of every other visit with the client to the LPN, who will conduct a focused assessment and report any changes or concerns	01620			

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01620	Continued From page 115 to the RN. The RN will reassess the client any time the client returns from a hospital or nursing home stay, has a change in condition, experiences an incident such as a fall, or experiences any unusual symptoms or possible side effects from medications. At these re-assessments, the RN will: a. review the client's service plan b. evaluate the client's medication management services and the client's medications c. evaluate the client's treatments, if any d. communicate any new problems or concerns to the client's physician or health care providers, and e. update the service plan as necessary based on the client's needs." "Re-assessments and ongoing client monitoring may be conducted at the client's residence or through the telecommunication methods based on practice standards that meet the client's needs. The result of the client monitoring visits and re-assessments will be documented by the licensed nurse." The licensee lacked a policy for assisted living resident assessment requirements. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On March 14, 2023, at 8:47 a.m. the immediacy was removed based on observations by the surveyor and record reviews by the evaluation supervisor; however, non-compliance remains at a scope and level of I. TIME PERIOD FOR CORRECTION: Two (2) Days	01620			

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01640 SS=F	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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure five of ten residents' (R6, R16, R1, R2, R7) service plans were revised to reflect the current services provided. In addition, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services provided for five of six residents (R16, R5, R1, R2, R7). This practice resulted in a level two violation (a	01640			

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01640	Continued From page 117 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 6, 2023, at 12:00 p.m. during the entrance conference, licensed assisted living director (LALD)-A stated nursing created the Service Plan, let the family know with all changes to the Service Plan, and have them (the resident or family) sign when there was a change in the fee as services changed. R6 R6 began receiving services under the licensee's ALFDC license on October 15, 2022. On March 7, 2023, at 7:20 a.m. the surveyor observed unlicensed personnel (ULP)-F assist with her TED stockings to both lower extremities. R6's Medication/Treatment/Therapy Management plan dated January 14, 2023, indicated 1. Services being provided include: compression garments (thrombo-embolic-deterrent (TED) stockings used for lower extremity swelling), with the instructions 1 a. Compression Garments-compression hose on in a.m. and off at bedtime. R6's Medication Administration Record (MAR) dated February 2023, indicated "Compression socks" [TED stockings] on 12 hours a day with the assigned time of 7:00 a.m.- 9:00 a.m., off 12 hours with the assigned time of 8:00 p.m.	01640			

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01640	Continued From page 118 Additional instructions included, "wear gloves when applying and removing so they do not get a snag in them." The MAR indicated a start date for the TED stockings of November 8, 2022. R6's undated, Service plan/Care Plan lacked the treatment service of TED stockings. Additionally, R6's Service Plan/Care Plan lacked a signature by R6 or R6's representative. R16 R16 began receiving services under the licensee's assisted living facility with dementia care (ALFDC) license on October 4, 2021. On March 7, 2023, at 8:00 a.m. registered nurse (RN)-C was observed to administer four oral medications to R16. R16's undated, Service Plan/Care Plan did not identify R16 received the service of medication administration. Additionally, R16's Service Plan/Care Plan lacked a signature by R16 or R16's representative. On March 8, 2023, at 4:00 p.m. RN-C stated she managed the Service Plan/Care Plan content for the residents and must have missed identifying some services. R5 R5 began receiving services under the licensee's comprehensive license on December 15, 2015, and then under the licensee's ALFDC license since August 1, 2021. R5's undated, Service Plan/Care Plan indicated she received services to include medication administration, bathing assistance, and every two	01640			

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01640	Continued From page 119 hour checks. R5's Service Plan/Care plan lacked a signature by R5 or R5's representative. On March 8, 2023, at 3:40 p.m. LALD-A stated she sat down and reviewed the schedule of fees, apartment information and level of care as determined by the registered nurse with the residents and/or the resident's representative. Additionally, LALD-A stated, "There will not be signatures for the Service Plans for any of the residents in the facility." R1 R1 was admitted to the facility under the comprehensive license on June 15, 2021, and later began receiving services under the assisted living with dementia care (ALFDC) license on August 1, 2021. On March 7, 2023, between 7:48 - 8:15 a.m. the evaluator observed unlicensed personnel (ULP)-D putting TED (thrombo-embolic deterrent) stockings (used to reduce swelling and prevent blood clots) on and administer eye drops to R1, who resided in the non-secured area of the building. R1's March 1, 2023, through March 7, 2023, medication administration record (MAR) identified TED stockings were to be applied daily on in the a.m. and removed in the p.m. R1's undated, Service Plan/Care Plan lacked the treatment service of the application of TED stockings. Additionally, R1's Service Plan/Care plan lacked a signature by R1 or R1's representative. R2 R2 was admitted to the facility under the ALFDC license on August 13, 2022.	01640			

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01640	Continued From page 120 On March 7, 2023, ULP-E checked blood glucose, administered insulin, and administered oral medications to R2. R2's March 1, 2023, through March 7, 2023, medication administration record (MAR) identified check blood sugar two times per day. R2's undated, Service Plan/Care Plan lacked the treatment service of blood glucose monitoring or medication administration. Additionally, R2's Service Plan/Care Plan lacked a signature by R2 or R2's representative. R7 R7 was admitted to the facility under the comprehensive license on February 20, 2018, and later the began receiving services under the ALFDC license on August 1, 2021. On March 7, 2023, at 7:21 a.m. ULP-D was observed to check a blood glucose on R7. ULP-D stated the result was 102 and R7 did not receive any sliding scale insulin, based on the test result. She then administered R7's Lantus insulin (pre-set up by a nurse into a syringe). R7's undated, Service Plan/Care lacked the service of medication set-up. Additionally, R7's Service Plan/Care Plan lacked a signature by R7 or R7's representative. On March 8, 2023, at 4:17 p.m. registered nurse (RN)-C stated she sets up insulin for R7, R8, R9, and R10. RN-C further stated on March 9, 2023, at 11:06 a.m. medication set up was not listed on any resident Service Plan/Care Plans. On March 9, 2023, at 11:06 a.m. registered nurse	01640			

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01640	Continued From page 121 (RN)-C stated when a resident has blood glucose monitoring or TED stockings, it is also not on the Service Plan/Care Plan. The licensee's undated, Development and Revision of the Service Plan policy indicated all home care services are provided in accordance with a suitable and up-to-date, written service plan, based on the individual client's needs and preferences. Except for temporary service plans, each service plan is signed by the RN, therapist, or other licensed health professional and the client and/or the client's representatives to the Service Plan. Each client's service plan is reviewed by the RN, therapist, or other licensed health professional (as applicable), as follows: -during each regular client monitoring visit, which occurs at least every 90 days; -whenever changes are needed to the services to be provided because of a change in the client's condition, after receipt of new or revised orders from the client's physician or other prescribing provider, following an incident, or following the client's return from a hospital or nursing home; -when our agency changes our fee schedule for services after giving prior notice of the modified fee schedule; and -if a review of the service plan indicates that the client's service plan needs modification based on the client's needs, preferences, or changes in fees, the RN, therapist and/or other licensed health professional (as applicable) makes necessary changes to the service plan, signs the revised service plan with name, title and date, and requests that the client and/or the client's representative sign and date the revised service plan. No further information was provided.	01640			

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01640	Continued From page 122	01640			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01650			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30707	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/13/2023
NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
(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
01650	Continued From page 123 review, the licensee failed to ensure the service plan included all required content for six of six residents (R1, R2, R5, R6, R7, R16). 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 included: R1 R1 began receiving services under the comprehensive license on June 15, 2021, and on August 1, 2021, under the assisted living facility with dementia care (ALFDC) license. On March 7, 2023, between 7:48 - 8:15 a.m. unlicensed personnel (ULP)-D applied TED (Thrombo-embolic-deterrent (TED) stockings used for lower extremity swelling) stockings and administered eye drops to R1. R1's March 1, 2023, through March 7, 2023, medication administration record (MAR) identified TED stockings were to be applied daily, on in the a.m. and removed in the pm. R1's unsigned and undated, Service plan/Care plan indicated R1 received assistance with bathing, medication administration, dressing, grooming, toileting, and bathing. The Service plan/Care plan lacked the service of TED stockings.	01650			

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01650	Continued From page 124 R2 R2 was admitted to the facility under the ALFDC license on August 13, 2022. On March 7, 2023, ULP-E checked blood glucose, administered insulin, and administered oral medications to R2. R2's March 1, 2023, through March 7, 2023, MAR identified check blood sugar two times per day. R2's unsigned and undated, Service plan/Care plan indicated he received assistance with housekeeping and laundry. R2's plan failed to identify he received medication administration. R5 R5 began receiving services under the licensee's comprehensive license on December 15, 2015, and beginning August 1, 2021, under the licensee's ALFDC license. R5's undated, Service Plan/Care Plan indicated she received services including medication administration, bathing assistance, and every two hour checks. On March 7, 2023, at 8:30 a.m. registered nurse (RN)-C was observed to administer eight oral medications to R5. R6 R6 began receiving services under the licensee's ALFDC license on October 15, 2022. R6's Medication/Treatment/Therapy Management plan dated January 14, 2023, indicated 1. Services being provided include: compression garments (TED) stockings with the instructions 1	01650			

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01650	Continued From page 125 a. Compression Garments- compression hose on in a.m. and off at bedtime. R6's MAR dated February 2023, indicated "Compression socks" [TED stockings] on 12 hours a day with the assigned time of 7:00 a.m.- 9:00 a.m., off 12 hours with the assigned time of 8:00 p.m. Additional instructions included, "wear gloves when applying and removing so they do not get a snag in them." The MAR indicated a start date for the TED stockings of November 8, 2022. On March 7, 2023, at 7:20 a.m. the surveyor observed ULP-F assist with her TED stockings to both lower extremities. R6's unsigned and undated, Service plan/Care Plan indicated she received the services of medication administration, bathing, and occasional toileting assistance; however, R6's Service Plan/Care Plan lacked the treatment service of TED stockings. R7 R7 began receiving services under the comprehensive license on February 20, 2018, and on August 1, 2021, under the ALFDC license. On March 7, 2023, at 7:21 a.m. ULP-D was observed to check a blood glucose on R7. ULP-D stated the result was 102 and R7 did not receive any sliding scale insulin, based on the test result. She then administered R7's Lantus insulin (pre-set up by a nurse into a syringe). R7's unsigned and undated, Service plan/Care plan indicated R7 received medication administration and blood glucose monitoring, but it failed to identify R7 received medication set-up.	01650			

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01650	Continued From page 126 R16 R16 began receiving services under the licensee's ALFDC license on October 4, 2021. On March 7, 2023, at 8:00 a.m. RN-C was observed to administer four oral medications to R16. R16's unsigned and undated, Service Plan/Care Plan did not identify R16 received the service of medication administration. The licensee failed to ensure the Service Plans for R1, R2, R5, R6, R7 and R16 included the required content of: - the identification of staff or categories of staff who will provide the services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that included: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those	01650			

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01650	Continued From page 127 chapters. On March 8, 2023, at 3:40 p.m. licensed assisted living director (LALD)-A stated she sat down and reviewed the schedule of fees, apartment information and level of care as determined by the registered nurse with the residents and/or the resident's representative. LALD-A stated she was not aware of the required content for the Service Plans since the conversion from the Comprehensive Licensure to the Assisted Living licensure that occurred in August 2021. LALD-A stated the corporate office was located in Wisconsin and the licensee's facility was the only assisted living facility in Minnesota. The licensee's undated, Contents of Service Plans policy indicated all home care clients have an up-to-date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional. The service plan contains all required information and, except for a temporary service plan, is signed by the RN and/or licensed health professional and by the client and/or the client's representative. A service plan established after completion of full individualized initial assessment and each subsequent reassessment included: - a description of the home care services, including nursing and medication management services, treatments and or therapy services, to be provided by our agency. - the frequency of each service, according to the client's current assessment and preferences. - the fees for the home care services our agency is providing. - identification of the expected source of payment (private pay by the client or client's representative, insurance, public programs, etc.). - the identification of the staff or categories of	01650			

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01650	Continued From page 128 staff that will provide the services. - the schedule and methods of monitoring reviews or re-assessments of the client. - the frequency of supervision of staff providing services and the identification of the supervisor(s) who will be providing the supervision. - A contingency plan that includes: i. The action to be taken by our agency, the client and/or client's representative if the scheduled service cannot be provided; ii. Information and method for a client or client's representative to contact our agency. iii. Names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition, including identification of and information as to who has authority to sign for the client in an emergency. iv. The circumstances in which emergency medical services are not to be summoned pursuant to provider orders related thereto. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650			
01700 SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face	01700			

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01700	Continued From page 129 with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for five of five residents (R5, R6, R1, R2, R7) receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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).	01700			

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01700	Continued From page 130 The findings include: During the entrance conference on March 6, 2023, at 12:00 p.m. director of health care services/registered nurse (DHCS/RN)-B confirmed the licensee provided medication management services to all of the residents receiving assisted living services. R5 R5 began receiving services under the licensee's comprehensive license on December 15, 2015, and on August 1, 2021, under the licensee's assisted living with dementia care license (ALFDC). R5's diagnoses included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, depression, and anxiety. R5's unsigned Service Plan/Care plan indicated she received services to include medication administration. R5's medication administration record (MAR) dated March 2023, included one heart medication, one supplement, one to manage irritable bowel, two for high blood pressure, one for gastric reflux, one for sleep, one for depression, one for dementia symptoms, one antibiotic, two for bowel management, one antacid, one as needed for chest pain, one for mild pain, and one for nausea. On March 7, 2023, at 8:30 a.m. RN-C was observed to administer medications to R5. R5's record lacked evidence the RN conducted a face-to-face review of all medications R5 was	01700			

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01700	Continued From page 131 known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R6 R6 began receiving services under the ALFDC license on October 15, 2022. R6's diagnoses included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R6's unsigned and undated, Service plan/Care Plan indicated she received the services of medication administration. R6's MAR dated March 2023, indicated R6 received two medications for hypertension (high blood pressure), one for edema (fluid retention), one for sleep, one supplement, one for pain, and two for constipation. On March 7, 2023, at 7:30 a.m. RN-C was observed to administer five medications to R6. R6's record lacked evidence the RN conducted a face-to-face review of all medications R6 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R1 R1 began receiving services under the comprehensive license on June 15, 2021, and on August 1, 2021, under the ALFDC license. R1's diagnosis included Alzheimer's disease, epilepsy, major depressive disorder, syncope and history of falls.	01700			

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01700	Continued From page 132 R1's unsigned and undated, Service plan/Care plan indicated R1 received assistance with medication administration. R1's MAR dated March 2023, indicated R1 received four heart medications, cholesterol medication, three supplements, a medication for gastric reflux, a medication for prostrate, two eye drops, a diuretic, an inhaler for respiratory disease, a medication for gout, an allergy medication, and a medication to help with sleep. On March 7, 2023, between 7:48 - 8:15 a.m. unlicensed personnel (ULP)-D administered eye drops to R1. R1's record lacked evidence the RN conducted a face-to-face review of all medications R1 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R2 R2 was admitted to the facility under the ALFDC license on August 13, 2022. R2's diagnoses included diabetes and mild cognitive impairment. R2's unsigned and undated, Service plan/Care plan indicated he received assistance with housekeeping and laundry. R2's plan failed to identify he received medication administration. R2's MAR dated March 2023, indicated R2 received a diuretic, three heart medications, three oral diabetic medication, insulin, thyroid medication, a cholesterol medication, an inhaler for respiratory disease, and two eye drops for	01700			

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01700	Continued From page 133 cataract surgery. On March 7, 2023, ULP-E administered insulin, and oral medications to R2. R2's record lacked evidence the RN conducted a face-to-face review of all medications R2 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R7 R7 began receiving services under the comprehensive license on February 20, 2018, and on August 1, 2021, under the ALFDC license. R7's diagnoses included diabetes, peripheral vascular disease, and hypertension. R7's unsigned and undated, Service plan/Care plan indicated R7 received medication administration, but failed to identify R7 received medication set-up. R7's MAR dated March 2023, indicated R7 received two types of insulin, pain medication, a diuretic, heart medication, cholesterol medication, a medication for loose bowel movements, and a vitamin. On March 7, 2023, at 7:21 a.m. ULP-D was observed to administer R7's Lantus insulin (pre-set up by a nurse into a syringe). R7's record lacked evidence the RN conducted a face-to-face review of all medications R7 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.	01700			

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01700	Continued From page 134 On March 13, 2023, at 2:45 p.m. director of health care services (DHCS)/RN-B confirmed the above records lacked evidence of the medication management assessment as required. The licensee's undated, Initial and On-going Nursing Assessment of Clients policy, indicated a specific assessment of the client's need for medication management services, including medication set up, medication administration, storing and securing medications, coordinating refills and changes to prescriptions and communicating with the pharmacy and the prescriber(s). If the RN believes the client may need medication management services, and the client refuses to have an assessment for medication management services, the RN will document this refusal, will explain the possible consequences of the refusal to the client and will document the discussion with the client of the potential consequences. The assessment of the client's need for medication management services must be face-to-face and must include: - identification and review of all medications the client is known to be taking; - indications for medications; - side effects; - contraindications; - allergic or adverse reactions and actions to address these issues; and - interventions needed to prevent diversion of the medications by the client or by others who may have access to the medications. Diversion includes misuse, theft, or illegal or improper disposition of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			

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01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed	01730			

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NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
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01730	Continued From page 136 when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan included all required content for five of five residents (R5, R6, R1, R2, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R5 R5's diagnoses included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, depression, and anxiety. R5's unsigned and undated, Service Plan/Care Plan indicated R5 received services to include medication administration. On March 7, 2023, at 8:30 a.m. registered nurse (RN)-C was observed to administer oral medications to R5 while in the dining room for breakfast. R5's medication administration record (MAR)	01730			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30707	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/13/2023
NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
(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
01730	Continued From page 137 dated March 2023, included one medication for the heart, one supplement, one to manage irritable bowel, two for high blood pressure, one for gastric reflux, one for sleep, one for depression, one for dementia symptoms, one antibiotic, two for bowel management, one antacid, one as needed for chest pain, one for mild pain, and one for nausea. R5's orders dated January 20, 2023, included Zofran, give 4 milligrams (mg) by mouth as needed for nausea. The order also included a second order for Zofran 4 mg, give by mouth every 12 hours as needed for nausea. The licensee failed to identify a duplicate as needed order for Zofran and failed to clarify which order ULP would follow. R5's Medication/Treatment/Therapy Plan dated February 5, 2023, lacked the required content to include: -a statement describing the medication management services that will be provided; and -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. On March 13, 2023, at 2:45 p.m. director of health care services/registered nurse (DHCS/RN)-B stated the multiple Zofran orders likely came from somewhere with an order in place when R5 was admitted and she didn't realize there were two orders. Additionally, DHCS/RN-B confirmed R5's Medication/Treatment/Therapy plan lacked the required content. R6	01730			

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NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
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01730	Continued From page 138 R6's diagnoses included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R6's unsigned and undated, Service plan/Care Plan indicated she received the services of medication administration. On March 7, 2023, at 7:30 a.m. RN-C was observed to administer oral medications to R6 while in the dining room for breakfast. R6's MAR dated March 2023, indicated R6 received two medications for hypertension (high blood pressure), one for edema (fluid retention), one for sleep, one supplement, one for pain, and two for constipation. R6's Medication/Treatment/Therapy Plan dated January 14, 2023, lacked the required content to include: -a statement describing the medication management services that will be provided; and -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. On March 13, 2023, at 2:50 p.m. DHCS/RN-B confirmed R6's Medication/Treatment/Therapy plan lacked the above indicated required content. R1 R1's diagnosis included Alzheimer's disease, epilepsy, major depressive disorder, syncope and history of falls. R1's unsigned and undated, Service Plan/Care Plan, indicated R1 received assistance with medication administration.	01730			

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NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
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01730	Continued From page 139 On March 7, 2023, between 7:48 - 8:15 a.m. the evaluator observed unlicensed personnel (ULP)-D administer eye drops to R1. R1's MAR dated March 2023, indicated R1 received four heart medications, cholesterol medication, three supplements, a medication for gastric reflux, a medication for prostrate, two eye drops, a diuretic, an inhaler for respiratory disease, a medication for gout, an allergy medication, and a medication to help with sleep. R1's Medication/Treatment/Therapy Plan dated March 4, 2023, lacked the required content to include: -a statement describing the medication management services that will be provided; and -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. R2 R2's diagnoses included diabetes and mild cognitive impairment. R2's unsigned and undated, Service Plan/Care Plan failed to identify he received medication administration. On March 7, 2023, ULP-E administered insulin and oral medications to R2. R2's MAR dated March 2023, indicated R2 received a diuretic, three heart medications, three oral diabetic medication, insulin, thyroid medication, a cholesterol medication, an inhaler for respiratory disease, and two eye drops for cataract surgery.	01730			

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NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
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01730	Continued From page 140 R2's Medication/Treatment/Therapy Plan dated August 8, 2022, lacked the required content to include: -a statement describing the medication management services that will be provided; and -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. R7 R7's diagnoses included diabetes, peripheral vascular disease, and hypertension. R7's unsigned and undated, Service Plan/Care Plan indicated R7 received medication administration, but failed to identify R7 received medication set-up. On March 7, 2023, at 7:21 a.m. ULP-D was observed to administer R7's Lantus insulin (pre-set up by a nurse into a syringe). R7's MAR dated March 2023, indicated R7 received two types of insulin, pain medication, a diuretic, heart medication, cholesterol medication, a medication for loose bowel movements, and a vitamin. R7's Medication/Treatment/Therapy Plan dated February 26, 2023, lacked the required content to include: -a statement describing the medication management services that will be provided; and -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions.	01730			

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01730	Continued From page 141 On March 8, 2023, at 4:17 p.m. RN-C stated she sets up insulin for R7. RN-C further stated on March 9, 2023, at 11:06 a.m. medication set up was not listed on the Medication/Treatment/Therapy Management Plan for any resident. The licensee's undated, Medication policy read the Home Care Director will determine which medication management services our agency will offer. The RN is responsible for the implementation of our agency's medication management policies and procedures. Based on the nursing assessment, the RN will develop an individualized medication management plan for each client receiving any type of medication management services, consistent with current practice standards and guidelines, and will develop specific procedures for medication management services that staff will provide. The RN will assure that unlicensed personnel are trained, competent and oriented to the client whenever unlicensed personnel are to perform medication management services for the client. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated	01750			

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01750	Continued From page 142 the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; 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 two of two unlicensed personnel (ULP-D and ULP-E) completed training and competency evaluations for medication administration prior to administering medications. This resulted in an immediate correction order identified on March 8, 2023, at 4:25 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D began providing cares under the Comprehensive license on May 24, 2021, and began providing services under the Assisted Living with Dementia Care (ALFDC) license on August 1, 2021. On March 7, 2023, ULP-D was observed completing the following tasks: - at 7:21 a.m., ULP-D checked blood glucose, administered oral medications, and administered	01750			

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01750	Continued From page 143 insulin to R7; and - at 8:15 a.m. ULP-D administered eye drops to R1. ULP-D's employee file contained a form labeled Initial Care Manager Orientation for Medication Pass identified columns labeled with the different routes of medication administration, Day 1, Day 2, Day 3, Day 4, Day 5, Observer's signature. Day 1 listed April 21, 2022, Day 2 listed April 22, 2022, day 3 listed April 24, 2022, Day 4 listed April 26, 2022, day 5 listed April 28, 2022, and the observer's signature indicated registered nurse (RN)-C. ULP-D's employee file lacked evidence she had been trained by a RN and was deemed competent to administer medications prior to completing medication administration to residents. ULP-E ULP-E began providing services under the ALFDC license on December 30, 2022. On March 7, 2023, ULP-E was observed completing the following tasks: - at 6:50 a.m., ULP-E checked blood glucose, administered oral medications, and administered insulin to R3; - at 7:02 a.m., ULP-E administered oral medications to R11; and - at 7:16 a.m., ULP-E checked blood glucose, administered insulin, and administered oral medications to R2. ULP- E's employee file contained a form labeled Initial Care Manager Orientation for Medication Pass, identified columns labeled with the different routes of medication administration, Day 1, Day	01750			

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01750	Continued From page 144 2, Day 3, Day 4, Day 5, Observer's signature. Day 1, day 2, day 3, day 4 were blank. Day 5 listed RN-C's initials. The observer's signature column listed the date of February 1, 2023. Insulin injections was not signed by the nurse as completed. ULP-E's employee file lacked evidence she had been trained by a RN and was deemed competent to administer medications to a RN prior to completing medication administration to residents. On March 8, 2023, at 3:40 p.m. RN-C stated the facility used to have staff complete a medication class with training by an RN until the previous director of health services left her position two years ago. Since that time, they have not had a medication class, and there was no training for medication administration by the RN prior to new employees completing those tasks. The Initial Care Manager Orientation for Medication Pass form identified the dates the new staff administered medications to the residents with an experienced staff member (another ULP) watching them. The final column was the nurse observing the new staff and signing them off as competent. The licensee's Training and Competency Evaluation of Unlicensed Staff policy, undated, identified "Unlicensed home care personnel will meet all orientation and training requirements and will be determined to be competent to perform all assigned tasks by the RN or by other Licensed Health Professional, when appropriate, before unlicensed personnel may provide any service to a home care client." Training and competency would be completed for the following: "Administering medications or treatments as	01750			

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01750	Continued From page 145 required (practical skills test required); and Training on all delegated tasks or assigned therapies that the unlicensed personnel will perform (practical skills test showing competency is required}." The licensee's Training Unlicensed Personnel for Medication Administration policy, undated, identified "Before the RN delegates the task of assistance with self-administration of medications or the task of medication administration, the RN must instruct the unlicensed personnel on performing these tasks and determine the unlicensed personnel as competent to perform the tasks." "The RN will document the training and competency of unlicensed personnel to properly administer each type of medication they are assigned to administer in the staff person's personnel record and in the spreadsheet that identifies which unlicensed personnel are competent to administer various types of medications." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On March 10, 2023, at 4:11 p.m.the immediacy was removed based on observations by the surveyor and record reviews by the evaluation supervisor; however, non-compliance remains at a scope and level of I. TIME PERIOD FOR CORRECTION: Two (2) Days	01750			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760			

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01760	Continued From page 146 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 document review, the licensee failed to document medication administration and failed to document reason or notify the nurse when medications were not given for residents reviewed (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 On March 7, 2023, at 8:15 a.m. ULP-D administered eye drops to R1. R1's medication administration record (MAR)	01760			

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01760	Continued From page 147 dated February 1, 2023, through February 28, 2023, identified the following: February 6, 2023, the following medications were left blank (no documentation that it was given or not given); - aspirin (heart health) - calcium (supplement) - eplerenone (diuretic) - pantoprazole (gastric reflux) - potassium (supplement) - tamsulosin (prostate) - torsemide (diuretic) - acetylcysteine (loosen mucous) - Advair (inhaler for respiratory problems) - metoprolol (heart) - Latanoprost (glaucoma) was blank for February 2, 2023 - Zyrtec (allergies) was not given February 6, 7, 8, 2023 There was no corresponding documentation to identify if these medications were administered or why the medications were not administered. R1's MAR dated March 1, 2023, through March 7, 2023, identified the following: - Amlodipine (blood pressure) was not administered on March 2, 3, and 6, 2023 - Atorvastatin (cholesterol) was not administered on March 6, 2023 - eplerenone was not administered on March 4, 2023 - potassium was not administered on March 1, 2023 - Cholchicine (gout) was not administered on March 4, 2023 There was no corresponding documentation to identify if these medications were administrated, or why the medications were not administered. R2	01760			

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01760	Continued From page 148 On March 7, 2023, at 7:16 a.m. ULP-E checked blood glucose, administered insulin, and administered oral medications to R2. R2's MAR dated February 1, 2023, through February 28, 2023, identified the following: February 6, 2023, and February 16, 2023, the following medications were left blank (no documentation that it was given or not given); - aspirin - furosemide (diuretic) - glipizide (diabetes) - isosorbide (heart) - Januvia (diabetes) - Lantus (insulin) - metoprolol - multivitamin - Dulera (inhaler for respiratory disease) - lisinopril (heart) - metformin (diabetes) There was no corresponding documentation to identify if these medications were administered, or why the medications were not administered. R2's MAR dated March 1, 2023, through March 9, 2023, identified the following: - furosemide was not administered on March 7, 2023 - Dulera was not administered on March 4, 5, 6, 7, 2023 - Metformin was not administered March 4 or March 5, 2023 There was no corresponding documentation to identify if these medications were administered, or why the medications were not administered. On March 13, 2023, at 1:20 p.m. director of health care services/registered nurse (DHCS/RN)-B stated she was unaware whether the medications were administered or not to the	01760			

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01760	Continued From page 149 residents. She was unaware of the blank spots on the MAR. She had not been notified by staff if the medications were not administered. Staff should report to the nurse when they are not giving a medication and should document why the medications were not given. The licensee's undated, Administration of Medications by Unlicensed Personnel identified: "1. Unlicensed personnel that will provide assistance with medication administration will be trained and competency tested by the RN on the following: a. The complete procedures for checking the client's medication administration record and medication profile; b. Infection control precautions that must be followed when administering medications; c. Preparation of the medication for the client when necessary; d. Administration of the medication to the client (or assistance with self-administration); e. Documentation, after assistance with self-administration of medications or medication administration, consistent with our agency's procedures for documenting the MAR; and f. The procedure for staff to notify the RN of any medications or dietary supplements that are being used by the client and that are not included in the assessment for med management services." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup	01770			

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NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
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01770	Continued From page 150 Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup was completed for four of four residents (R7, R8, R9, and R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 7, 2023, at 7:21 a.m. unlicensed personnel (ULP)-D checked blood glucose and administered Lantus insulin in a set up pre-filled syringe to R7. ULP-D stated the nurse sets up the insulin. On March 8, 2023, at 4:17 p.m. registered nurse (RN)-C stated she sets up insulin for R7, R8, R9, and R10 and does not document the set up. R7, R8, R9, and R10's unlabeled documents had multiple label squares that contained the medication information. RN-C would put a date	01770			

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NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
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01770	Continued From page 151 on one of the squares when she filled the insulin syringes. The documents failed to have the dates listed that the medications were filled for administration. On March 9, 2023, at 8:15 a.m. RN-C verified all documents failed to contain the dates the medication had been set up for; therefore, the medication set up documentation did not have all the required content. The licensee's undated, Medication Administration System - Dosage Box Set-up policy identified the following: - "The RN or LPN will transcribe medication prescription onto the Medication Profile. This profile will include: a. Medication name and strength b. Dosage of medication c. Visual description of medication [or picture] d. Day and time of administration e. Route of administration f. Drug classification and special precautions g. Any specific instructions for administering the medication to the client." - "The RN or LPN will transcribe the medication prescription onto the Medication Administration Record (MAR). For medications included in the dosage box, the day and time of administration will be noted on the MAR." - "When the RN or LPN has completed setting up the medications into the Dosage Box, the nurse will document each individual medication that has been set up on the MAR." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			

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01820	Continued From page 152	01820			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for all medications the provider managed for one of five residents (R15). 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: R15 R15 started receiving services under the licensee's assisted living with dementia care license on March 3, 2023. R15's Service Plan/Care Plan was requested, but was not provided. On March 7, 2023, at 8:05 a.m. registered nurse (RN)-C was observed to administer six oral medications to R15.	01820			

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01820	Continued From page 153 R15's medication administration record (MAR) dated March 4, 2023, through March 7, 2023, indicated the following medications were administered without current signed physician orders: -levothyroxine 75 micrograms (mcg), one tablet by mouth, one time daily for the thyroid; -mirtazapine 7.5 milligrams (mg), one tablet by mouth, one time daily for depression; -risperidone 0.25 mg, one tablet by mouth, one time daily for behaviors; -senna-s 8.6-50 mg, one tablet by mouth, one time daily for constipation; -sertraline 100 mg, one tablet by mouth, one time daily for depression; -multivitamin, one tablet by mouth, one time daily as a supplement; -acetaminophen 500 mg, two tablets by mouth, two times daily for pain; and -divalproex 125 mg, one tablet by mouth, two times daily for depression. On March 7, 2023, at approximately 2:00 p.m. the surveyor requested R15's signed physician orders. The licensee provided the surveyor with a printed medication list; however, the list was not signed by R15's provider. On March 13, 2023, at 2:55 p.m. director of health care services/registered nurse (DHCS/RN)-B stated, "you will need to ask RN-C for that [a signed medication list], it may be in a pile not yet scanned into the system." The licensee's undated, Content of Medication Prescriptions and Treatment or Therapy Orders indicated the RN or appropriate Licensed Health Professional is responsible for assuring that current, authorized prescriber prescriptions for	01820			

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01820	Continued From page 154 medications and orders for treatments and therapies, to be administered by the staff are kept in the client's record and that changes in orders are addressed in the client's care plan, service plan and Medication Administration Record, if applicable, and are communicated on a timely basis to all appropriate staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to renew prescriptions at least every 12 months for one of seven residents (R16). 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:	01830			

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01830	Continued From page 155 R16 R16 began receiving services by the licensee's assisted living facility with dementia care (ALFDC) license on October 4, 2021. R16's unsigned and undated, Service Plan/Care Plan did not include the service of medication administration. On March 7, 2023, at 8:00 a.m. registered nurse (RN)-C was observed to administer four oral medications to R16. R16's medication administration record (MAR) dated March 1, 2023, through March 7, 2023, included the following medications, but lacked current orders: -aspirin 81 milligrams (mg), one tablet by mouth, one time daily for heart health; -levothyroxine 50 micrograms (mcg), one tablet by mouth, one time daily for the thyroid; -metoprolol Succinate extended release (ER), one capsule by mouth, one time daily for high blood pressure; -potassium chloride Solution, 15 milliliters (ml) by mouth, one time daily for low potassium; -potassium chloride Solution, 7.5 ml by mouth, one time daily for low potassium; -Remeron 15 mg, one tablet by mouth, one time daily for depression/sleep; and -senna-docusate 8.6-50 mg, one tablet by mouth twice daily as needed for constipation. The licensee provided a medication list which included the above listed medications signed by R16's provider dated October 1, 2021; and provided additional orders for potassium chloride dated November 4, 2021, and senna-docusate dated November 29, 2021.	01830			

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01830	Continued From page 156 On March 13, 2023, at 3:00 p.m. director of health care services/registered nurse (DHCS/RN)-B stated she believed there were more current orders, dated February 2022, but nothing since that time. The licensee's undated, Content of Medication Prescriptions and Treatment or Therapy Orders policy read The RN or Licensed Health Professional will assure that the prescriber renews a medication prescription or treatment or therapy order at least every 12 months, or more frequently if determined necessary based on the nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one medication cart was securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all residents residing in the facility.	01880			

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01880	Continued From page 157 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 7, 2023, at 7:48 a.m. unlicensed personnel (ULP)-D was in R1's room and applied TED (thrombo-embolic deterrent) stockings (compression stockings used to increase circulation and decrease swelling) to R1. On March 7, 2023, at 8:01 a.m. surveyor noted the first floor medication cart was unlocked and no staff were present. During continuous observation from 8:01 a.m. through 8:11 a.m., the following was observed; - director of admissions (DA)-H walked past the unlocked medication cart; - maintenance staff (MS)-G walked past the unlocked medication cart; - two unidentified unlicensed staff walked past the unlocked medication cart; and - R4 walked past the unlocked med cart At 8:11 a.m., ULP-D returned to the unlocked medication cart and stated she had been in R1's room since the observation of TED hose placement at 7:48 a.m. ULP-D then removed eye drops from the unlocked medication cart and started down the hall without locking the cart. The surveyor intervened and asked if the medication cart should be locked. ULP-D stated "oh, yeah", returned to the cart and locked it. On March 9, 2023, at 8:55 a.m. director of health	01880			

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01880	Continued From page 158 care services/registered nurse (DHCS/RN)-B stated the medication cart should be locked at all times when staff are not present at the cart. The licensee's undated, Storage of Medications policy identified "In the client's individualized medication management plan, the RN may identify the need for secured storage of the medications within the client's private living space or in a the medication cart or medication room because of the client's cognitive status, concerns about medication diversion or other concerns, When secured storage of the medications is necessary, the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications." There was no further information regarding secure storage of medications in the medication cart. No further information was provided. TIME PERIOD FOR CORRECTION: seven (7) days	01880			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01890			

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01890	Continued From page 159 review, the licensee failed to ensure medications had a pharmacy label for one of two residents (R2) with an insulin pen. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On March 7, 2023, at 7:16 a.m. unlicensed personnel (ULP)-E checked R2's blood glucose, administered insulin, and administered oral medications. R2's Lantus Solostar pen did not have a pharmacy label. Hand written on the pen was R2's name and a date "3/4" (March 4, 2023). On March 9, 2023, at 8:55 a.m. director of health care services/registered nurse (DHCS/RN)-B stated all medications should have a pharmacy label. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a	01910			

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01910	Continued From page 160 resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the required content for one of one discharged resident. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on March 6, 2023, licensed assisted living director (LALD)-A provided the discharge resident roster. The discharge roster indicated R14 began receiving	01910			

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01910	Continued From page 161 services on December 1, 2015, but lacked the date when R14 was discharged. LALD-A stated R14 had gone to the hospital on February 22, 2023, and was discharged directly to a skilled nursing facility following that hospitalization. R14's unsigned and undated, Service Plan/Care Plan indicated services included medication administration. R14's February 2023, medication administration record (MAR) was requested, but was not provided. R14's record included an unsigned and undated, medication list which included acetaminophen (mild pain), amlodipine (high blood pressure), Aspercreme lotion (mild pain), bupropion (mood), buspirone (anxiety), calcium carbonate (supplement), Cerovite (multivitamin), Culturelle (bowel supplement), Excedrin Migraine (migraine relief), fexofenadine (allergies), ibuprofen (mild pain), levothyroxine (thyroid), Lexapro (depression), loperamide (diarrhea), melatonin (sleep), Metamucil (bowel), naproxen (pain/anti-inflammatory), pantoprazole (acid reflux), risperidone (schizophrenia), rizatripan (migraine), Sinemet (muscle spasms, tremors), Topamax (migraine), trazodone (sleep), and vitamin D (supplement). On March 9, 2023, at 2:05 p.m. registered nurse (RN)-C stated there was no record of disposition of medications for R14. The licensee's undated, Disposition or Disposal of Medication Home Care policy, indicated Drugs Given to Clients When the Medication Management Services Have Been Terminated: -a client's current medications that are secured or	01910			

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01910	Continued From page 162 stored by our agency will be given to the client or the client's representative when the client's medication management services are terminated, except that the conditions listed below must be met before controlled medications belonging to a client will be given to the client or the client's representative; and -staff will document in the client's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01940 SS=F	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	01940			

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01940	Continued From page 163 appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management plan to include all required content for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the facility under the comprehensive license on June 15, 2021, and later began receiving services under the assisted living with dementia care (ALFDC) license on August 1, 2021. R1's diagnosis included Alzheimer's disease,	01940			

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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
01940	Continued From page 164 epilepsy, major depressive disorder, syncope and history of falls. On March 7, 2023, between 7:48 - 8:15 a.m. the surveyor observed unlicensed personnel (ULP)-D putting on R1's TED (thrombo-embolic deterrent) stockings (used to reduce swelling and prevent blood clots) and administer eye drops. R1's March 1, 2023, through March 7, 2023, medication administration record (MAR) identified TED stockings were to be applied daily on in the a.m. and removed in the p.m.. R1's unsigned and undated, Service Plan/Care Plan indicated R1 received assistance with bathing, medication administration, dressing, grooming, toileting, and bathing. The treatment of TED stockings was not identified on the service plan. R2 R2 was admitted to the facility under the ALFDC license on August 13, 2022. R2's diagnoses included diabetes and mild cognitive impairment. On March 7, 2023, at 7:16 a.m. ULP-E checked blood glucose, administered insulin, and administered oral medications to R2. R2's March 1, 2023, through March 7, 2023, medication administration record (MAR) identified check blood sugar two times per day. R2's unsigned and undated, Service Plan/Care Plan indicated he received assistance with housekeeping and laundry. R2's plan failed to identify he received blood glucose monitoring.	01940			

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01940	Continued From page 165 On March 9, 2023, at 11:06 a.m. registered nurse (RN)-C stated when a resident has blood glucose monitoring or TED stockings, it was not included on the service plan/care plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940			
01950 SS=I	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-D and ULP-E)	01950			

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01950	Continued From page 166 completed training and competency evaluations for blood glucose testing. This resulted in an immediate correction order identified on March 8, 2023, at 4:25 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D began providing cares under the Comprehensive license on May 24, 2021, and began providing services under the Assisted Living with Dementia Care (ALFDC) license on August 1, 2021. On March 7, 2023, at 7:21 a.m. ULP-D was observed to check a blood glucose on R7. ULP-D stated the result was 102 and R7 did not receive any sliding scale insulin, based on the test result. She then administered R7's Lantus insulin (pre-set up by a nurse into a syringe). ULP-D's employee file contained a form labeled Initial Care Manager Orientation for Medication Pass identified columns labeled with the different routes of medication administration and Accuchecks (blood glucose testing), Day 1, Day 2, Day 3, Day 4, Day 5, and the Observer's signature. Day 1 listed April 21, 2022, Day 2 listed April 22, 2022, day 3 listed April 24, 2022, Day 4 listed April 26, 2022, day 5 listed April 28, 2022, and the observer's signature indicated registered	01950			

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01950	Continued From page 167 nurse (RN)-C. ULP-D's employee file lacked evidence she had been trained by a nurse and had been deemed competent to check blood glucose to a RN prior to completing blood glucose testing on residents. ULP-E ULP-E began providing services under the ALFDC license on December 30, 2022. On March 7, 2023, ULP-E was observed completing the following tasks: - at 6:50 a.m., ULP-E checked blood glucose, administered oral medications, and administered insulin to R3; and - at 7:16 a.m. ULP-E checked blood glucose, administered insulin, and administered oral medications to R2 ULP- E's employee file contained a form labeled Initial Care Manager Orientation for Medication Pass identified columns labeled with the different routes of medication administration and Accuchecks (blood glucose testing), Day 1, Day 2, Day 3, Day 4, Day 5, and Observer's signature. Day 1, day 2, day 3, day 4 were blank. Day 5 listed RN-C's initials, observer's signature listed the date of February 1, 2023. ULP-E's employee file lacked evidence she had been trained by a RN and had been deemed competent to check blood glucose to a nurse prior to completing blood glucose testing on residents. On March 8, 2023, at 3:40 p.m. RN-C stated the facility used to have staff complete a medication class (which included blood glucose testing) with training by an RN until the previous director of	01950			

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01950	Continued From page 168 health services left her position two years ago. Since that time, they have not had a medication class, and therefore no training for blood glucose monitoring was completed by the RN prior to new employees completing those tasks. The Initial Care Manager Orientation for Medication Pass form identified the dates the new staff administered completed blood glucose monitoring on the residents with an experienced staff member (another ULP) observing them. The final column was the nurse observing the new staff and signing them off as competent. The licensee's Training and Competency Evaluation of Unlicensed Staff policy, undated, identified "Unlicensed home care personnel will meet all orientation and training requirements and will be determined to be competent to perform all assigned tasks by the RN or by other Licensed Health Professional, when appropriate, before unlicensed personnel may provide any service to a home care client." Training and competency would be completed for the following; "Administering medications or treatments as required (practical skills test required); and Training on all delegated tasks or assigned therapies that the unlicensed personnel will perform (practical skills test showing competency is required})." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On March 10, 2023, at 4:11 p.m. the immediacy was removed based on observations by the surveyor and record reviews by the evaluation supervisor; however, non-compliance remains at a scope and level of I.	01950			

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01950	Continued From page 169	01950			
	TIME PERIOD FOR CORRECTION: Two (2) Days				
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents. The findings include: On March 07, 2023, from approximately 10:30	02040			

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02040	Continued From page 170 a.m. to 12:30 p.m., survey staff toured the facility with MD-I and DA-H. During the facility tour, survey staff requested a facility hazard vulnerability or safety risk assessment documentation, but the licensee did not provide the requested documentation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040			
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented;	02110			

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02110	Continued From page 171 (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care and failed to provide the policies and procedures to residents and the residents' legal and designated representatives at the time of move-in. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2022. The licensee lacked the following policies and procedures related to dementia care:	02110			

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02110	Continued From page 172 - philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities are implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. Additionally, the licensee failed to ensure the dementia policies and procedures were provided to residents and the residents' legal and designated representatives at the time of move-in. On March 8, 2023, at 4:05 p.m. licensed assisted living director (LALD)-A stated the licensee currently lacked dementia care policies. No further information was provided TIME PERIOD FOR CORRECTION: Twenty-One	02110			

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02110	Continued From page 173 (21) days	02110			
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 6, 2023, at 11:45 a.m. licensed assisted living director (LALD)-A and director of health care services/registered nurse (DHCS/RN)-B, stated RN-C oversaw all staff training and could speak	02140			

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02140	Continued From page 174 to the dementia training for the staff. On March 8, 2023, at 4:00 p.m. RN-C stated the previous director of health care services had managed the dementia training. RN-C stated she had not completed any approved competency or knowledge test required for supervising staff in an assisted living facility with dementia care and was unaware of the requirement. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	02140			
02240 SS=F	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and	02240			

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02240	Continued From page 175 Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided and a written acknowledgement was received from four of four residents (R1, R2, R5, and R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	02240			

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02240	Continued From page 176 The findings include: The facility converted to an Assisted Living with Dementia Care (ALFDC) license on August 1, 2021. R1 R1 began receiving assisted living services on August 1, 2021. R1's record included a an acknowledgement of receipt of Minnesota Bill of Rights for Assisted Living Residents on June 15, 2021. R2 R2 began receiving assisted living services on August 13, 2021. Acknowledgement of receipt of Minnesota Bill of Rights for Assisted Living Residents was requested but it was not received. R5 R5 began receiving assisted living services on August 1, 2021. R5's record included a an acknowledgement of receipt of Minnesota Bill of Rights for Assisted Living Residents on February 12, 2021. R6 R6 began receiving assisted living services on October 15, 2022. R6's record included a an acknowledgement of receipt of Minnesota Bill of Rights for Assisted Living Residents on October 18, 2022. R1, R2, R5, and R6's records lacked evidence the residents received the updated Minnesota Bill	02240			

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02240	Continued From page 177 of Rights for Assisted Living Residents dated August 12, 2022. On Mar 7, 2023, at 11:09 a.m. licensed assisted living director (LALD)-A stated all residents would have received the Minnesota Bill of Rights for Assisted Living Residents dated May 16, 2021. LALD-A was unaware of the updated version dated August 12, 2022. The licensee's undated, Home Care Bill of Rights policy identified "Our agency ensures that each client receives a copy of the Home Care Bill of Rights that is current and applicable to our agency's services. All of our staff receive training about the bill of rights and are expected to adhere to these rights." The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240			
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	02310			

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NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 178 health care and medical, or nursing standards for one of one resident (R1) with bilateral half side rails. This resulted in an immediate correction order on March 10, 2023, at 7:20 a.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 10, 2023, at 6:48 a.m. the surveyor observed upper right half side rails on R1's hospital bed. R1's diagnosis included Parkinson's disease, diabetes, and mild cognitive impairment. R1's care plan identified as the service plan, undated and unsigned, indicated R1 received assistance with bathing, medication administration, ace wrap placement, dressing, grooming and bathing. R1's record lacked evidence a side rail assessment had been completed, or risks and benefits had been discussed with the resident or the resident's representative. R1 was not interviewable. On March 10, 2023, 10:36 a.m. ULP-J and ULP-K stated R1 used the side rail to reposition in bed,	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30707	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/13/2023
NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 179 assist to sit up in bed, and assist to stand up and transfer. On March 10, 2023, at 7:06 a.m. director of health care service/registered nurse (DHCS/RN)-B stated she was unaware R1 had side rails, therefore no assessment including measurements of the side rails zones 1-4 had been completed, and the risks and benefits of side rail use had not been explained. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than four and three quarters' inches. The Food and Drug Administration (FDA), "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The licensee's Assessing the Safety of Side rails policy undated, identified "Staff will alert the RN if a client has any type of side rail or similar equipment and the RN will then evaluate whether the side rail appears to be safe for the client. The RN will educate the client, the client's representative and/or family members about the risks related to side rails, and if the client's side	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30707	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/13/2023
NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA			STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 180 rail does not appear to meet FDA standards, the RN will recommend to the client, the client's representative, the client's involved family members that the side rail be removed and will recommend alternative options to reduce the risk of a fall out of bed. The RN will document these conversations and recommendations. - The RN will train staff to be alert for any side rail or equipment that resembles a side rail that a client may be using or considering using and to notify the RN immediately about the side rail or equipment. - When notified that a client has a side rail, the RN will assess and evaluate what the client's needs are and assess to determine if the client can safely utilize the side rail/equipment and determine whether the side rail/equipment meets the FDA standards for side rails. - The RN will provide for any client who has a side rail or is considering obtaining one and, if appropriate, the RN will educate the client's representative and/or the client's family regarding side rail safety and risks including potential death due to falls, entrapment and asphyxiation. If the RN determines that the client is not able to safely use a side rail, or that the client's side rail docs not meet the FDA or most current safety guidelines, the RN will recommend that the side rail should be removed and will document this recommendation, will document to whom the education was directed and will document the person who was given the recommendation to remove the side rail." The policy included the information from the FDA regarding side rails. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30707	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/13/2023
NAME OF PROVIDER OR SUPPLIER OAK PARK PLACE OF ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP CODE 1615 BRIDGE AVENUE ALBERT LEA, MN 56007			
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02310	Continued From page 181 On March 10, 2023, at 4:14 p.m. the immediacy was removed based on observations by the surveyor and record reviews by the evaluation supervisor; however, non-compliance remains at a scope and level of G. TIME PERIOD FOR CORRECTION: Two (2) Days	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: 03/07/23
Time: 08:42:22
Report: 8044231081

Food and Beverage Establishment Inspection Report

Page 1

Location:

Oak Park Place Of Albert Lea
1615 Bridge Avenue
Albert Lea, MN56007
Freeborn County, 24

Establishment Info:

ID #: 0038978
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073735600
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.

5-200B Plumbing: cross connections

5-203.14E **** Priority 1 ****

MN Rule 4626.1085A Mount the spray arm so it cannot hang below the spill rim of a sink or provide an approved backflow prevention device on the faucet.

Spray hanging below spill rim of prep sink.

Either shorten the hose or re-attach the spring so it does not hang below the spill rim.

Comply By: 03/21/23

6-200 Physical Facility Design and Construction

6-201.13A

MN Rule 4626.1345A Properly cove and seal the wall/floor junctures to no larger than 1/32 inch (1 millimeter).

No coved base in memory care food service area.

Remove wooden baseboards and replace with a rubber base cove.

Comply By: 05/07/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

Type: Full
Date: 03/07/23
Time: 08:42:22
Report: 8044231081
Oak Park Place Of Albert Lea

Food and Beverage Establishment Inspection Report

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Sign not posted at handwashing sinks in kitchen or memory care serving area.

Comply By: 03/08/23

Surface and Equipment Sanitizers

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

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40.1 Degrees Fahrenheit - Location: Cut tomatoes in upright 1
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38.7 Degrees Fahrenheit - Location: Ham in upright 1
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40.0 Degrees Fahrenheit - Location: Upright 1
Violation Issued: No

Process/Item: Hot Holding
Temperature: 135.4 Degrees Fahrenheit - Location: Oatmeal
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40.2 Degrees Fahrenheit - Location: Milk in upright 2
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41.0 Degrees Fahrenheit - Location: Upright 2
Violation Issued: No

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

HRD inspection conducted with lead evaluator Deb Jacobson and Stacy Haag. Inspection report reviewed on site with Director of Food Service Sherri Johanessen.

Type: Full
Date: 03/07/23
Time: 08:42:22
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Oak Park Place Of Albert Lea

Food and Beverage Establishment Inspection Report

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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 8044231081 of 03/07/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Signed: 
Inspector signed for Sherri

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