Electronically Delivered

March 3, 2025

Licensee
Bridges Of Zumbrota
295 West 4th Street
Zumbrota, MN 55992

RE: Project Number(s) SL20583016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 23, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH 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.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20583	A. BUILDING: _____ B. WING _____	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES OF ZUMBROTA	295 WEST 4TH STREET ZUMBROTA, MN 55992

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0 000	Initial Comments 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: SL20583016-0 On January 21, 2025, through January 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 22 residents; 11 receiving services under the Assisted Living Facility license.	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 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 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 evaluators ' 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 SUBDIVISION 1-3.	

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0 470	Continued From page 1	0 470		
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 sufficient staffing to meet the needs of the residents, who required medication management services during the overnight. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 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 of the residents). The findings include: On January 21, 2025, at 9:20 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated they provided medication management services and scheduled a minimum of one unlicensed personnel (ULP) for each shift. CNS-B stated the overnight shift was staffed by a ULP from the attached nursing home. Corporate quality director (CQD)-C stated the licensee had an approved Variance to utilize the nursing home ULP for overnight coverage (10:00 p.m., to 6:00 a.m.). The licensee's Assisted Living Licensure Rules Variance Request document approved on February 7, 2023, indicated: -From 10:00 p.m., to 6:00 a.m., a cross trained CNA (certified nursing assistant) would carry the call light pager and cell phone that alerts when a resident needs assistance, or a phone call is made to the facility. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated December 9, 2024, indicated the licensee provided medication management services. The UDALSA did not indicate the licensee did not provide medication management services during the overnight shift.	0 470		

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0 470	Continued From page 3 On January 22, 2025, at 6:05 a.m., the surveyor observed ULP-D ad ULP-E complete shift to shift report. ULP-E was the ULP from the nursing home that covered the overnight shift. ULP-E stated she comes over to the licensee every two to three hours to do rounds and would come over anytime if a resident called for assistance. ULP-E stated the pager and cell phone she carried would alert her if a call light was used. The surveyor inquired about administering medications to the assisted living residents. ULP-E stated she was a trained medication aide (TMA) for the nursing home but none of the ULP from the nursing home were trained or allowed to administer medications in the assisted living. ULP-E stated if a resident requested a medication, she would call the on-call nurse. On January 22, 2025, at 7:56 a.m., CNS-B stated the nursing home ULP that covered the overnight shift were not trained in medication management and could not administer any medications to the residents. The surveyor inquired what would happen if a resident requested a PRN (as needed) medication during the overnight shift. CNS-B stated the resident would have two options. One option being to call a family member in to administer the medication; however, family does not have access to the locked medication cabinets. The second option would be to call emergency medical services (EMS) and be brought into the emergency department to receive the medication. CNS-B stated she told residents upon admission that the facility does not provide medication management services during the overnight shift. On January 22, 2025, at 11:00 a.m., CQD-C stated the licensee had difficulty filling the overnight shift for ULP which is why they had the	0 470		

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0 470	Continued From page 4 variance in place to utilize the attached nursing home ULP for the overnight shift in assisted living. CQD-C stated the nursing home ULP received all the required Assisted Living training; however, they did not receive training on medication management services since they did not administer medications. CQD-C stated a resident would not be able to receive a medication during the overnight shift unless a family member gave it to them, or they went to the emergency department to receive it. CQD-C reviewed the licensee's UDALSA and stated it did not indicate medication management services were not available during the overnight shift of 10:00 p.m., to 6:00 a.m. The licensee's Administration ad Documentation of PRN Medications policy, undated, indicated the licensee would provide PRN medications within the parameters specified in the prescriber's prescription and with the procedures identified by the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a	0 480		

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0 480	Continued From page 5 certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and	0 480		

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0 480	Continued From page 6 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 21, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 495 SS=F	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week.	0 495		

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0 495	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) was available 24 hours a day, seven days a week. This had the potential to affect all residents and staff of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 of the residents). The findings include: On January 21, 2025, at 9:10 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated she would be the one to come into the facility to complete assessments when a resident had a change in condition in the evening/night hours or weekends. R1 was admitted on December 1, 2023, with diagnoses that included diabetes and edema (swelling caused by fluid buildup in the body's tissues). On January 22, 2025, at 8:41 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's service plan dated January 9, 2025, indicated R1 received services to include bathing, TED hose (thrombo-embolic deterrent) (stockings that help prevent blood clots), housekeeping,	0 495		

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0 495	Continued From page 8 laundry, diabetic management, and medication management. R1's progress notes dated December 23, 2024, at 4:45 p.m., noted the following: "RA [resident assistant (ULP)] went to check on resident and heard resident yelling for help. Upon entry into her apartment, RA found resident wedged in between her closet door and her recliner with her electric scooter on her left foot. When RA attempted to move the scooter off of resident she yellowed out in pain so RA called EMS (emergency medical services) for assistance and she was taken to the ED (emergency department). Resident was wearing her pendant but could not reach it as she was laying on it. Resident returned later in the evening with 2 new abrasions on her left shin, daily dressing change orders as well as 3 day prescription for Oxycodone. Informed RA and resident that since the RN is out of the office until Thursday, resident will need to have a family member or friend perform the dressing change as the RA"s have not been trained on this dressing. Resident stated she would have her daughter or friend help her out. Resident reported that she got her sleeve caught on the "joystick" of her electric scooter and it propelled her forward as she was trying to get out of the scooter. No other injuries noted." R1's progress notes dated December 26, 2024, at 9:00 a.m., noted the following: "Resident sustained 2 abrasions on her left medial shin post fall on 12/23/24. Orders included daily dressing changes. RN was not scheduled to be back into the office until 12/26/24 so resident was to have a family member or friend perform the dressing change on 12/24/24 & 12/25/24. On 12/26/24, RN removed old dressing from left shin.	0 495		

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0 495	Continued From page 9 2 separate abrasions present, both with beefy red wound beds along with a small amount of yellow slough (15%). Small amount of serosanguinous drainage presents on dressing. No odor or s/s of infection. Measurements: Upper shin abrasion- 4 cm L, 2 cm W & 1 cm D. Lower shin abrasion was 2.2 cm L, 1.6 cm W and 1 cm D. Cleansed both wounds with wound cleanser and pat dried with 4x4 gauze pad. Cut a piece of Vaseline gauze to size and covered each wound bed, covered with a soft roll of gauze and secured with a compressive ace wrap bandage. Areas very tender to the touch. Orders were for daily dressing changes; however, RN called/fax resident PCP and requested frequency to be changed to 3 times per week as the RN is not here on weekends and this is not a dressing change the RA's can perform. PCP set orders for 3 times per week and PRN if loose or soiled". R1's progress notes dated January 3, 2025, at 11:31 a.m., noted the following: "Performed dressing change on resident's let shin abrasions. Removed old dressings, cleansed both wounds with wound cleanser and pat dried with gauze pads. Both wounds have a beefy red appearance, no s/s/ of infection present, no order and resident is afebrile. There is a small dark area in the upper right corner of the upper abrasion, too small to measure. No other changes at this time. Cut Vaseline gauze to size and applied to wound bed of each abrasion. Covered with roll gauze and secured with tape. Ace compression wrap applied over dressing. Wounds have had an increase in serosanguinous drainage where the dressing could now be changed daily. Faxed doctor for an order to increase frequency to a daily on 12/31/24. RA's	0 495		

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0 495	Continued From page 10 individually trained on how to change residents dressing so this can be done when the RN is not present. Hematoma above the top abrasion still present and tender to touch. Resident reported she sees doctor on Monday as the PCP called her post fax by RN so PCP can assess her wound. Measurements: Top abrasion is 4.1 cm L x 2.1 cm W x 1 cm D. Lower abrasion is 2.1 cm L, 1.5 cm L x 1 cm D". On January 22, 2025, at 9:01 a.m., R1 stated when she returned from the hospital on December 23, 2024, she required daily wound care on her left leg. R1 stated she was told by the staff that the nurse was out of the office for a few days and would have to complete the wound care herself or have a family member help her. R1 stated she was able to find someone to help her with the wound care until the nurse was back in the office three days later. On January 22, 2025, at 11:50 a.m., corporate quality director (CQD)-C stated the nurse was expected to come on site to complete change of condition assessments which included assessing R1's wound care. CQD-C stated she spoke with the CNS-B on these expectations going forward. The licensee's Staffing Plan policy dated March 7, 2022, indicated an RN would be available by phone 24 hours per day, 7 days a week. Assisted Living Facilities: Minnesota Rules Chapter 4659.0140 Subpart 2 B. (2) indicates a nursing assessment must be conducted in person unless there is an exception under 144G.70 Subd. 2 paragraph (b), which only applies to prospective residents, not current residents ready to return from a hospitalization. Additionally,	0 495		

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0 495	Continued From page 11 Subpart 7 indicates an assisted living facility must be able to conduct a nursing assessment on a holiday or weekend for a resident who is ready to be discharged from the hospital and return to the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 495		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or	0 620		

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	20583	A. BUILDING: _____ B. WING _____	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES OF ZUMBROTA	295 WEST 4TH STREET ZUMBROTA, MN 55992

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0 620	Continued From page 12 (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report an incident of suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of three residents (R5).	0 620		

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0 620	Continued From page 13 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: On January 21, 2025, at approximately 9:10 a.m. during the entrance conference, a request was made to licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B to review all vulnerable adult reports the licensee had made to MAARC in the last six months. R5 was admitted on April 14, 2022, with diagnoses that included dementia and bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs). R5's service plan dated July 11, 2024, indicated R5 received services to include medication administration and assistance with activities of daily living. A MAARC report submitted on October 11, 2024, at 9:56 a.m., indicated the estimate date of incident as September 22, 2024, at 11:45 a.m. The report noted the following: "Resident was found by another resident on the floor in the foyer of the building. Upon arrival of resident assistant, resident stated she came downstairs to check her mail; however, she did not have her keys with her, she was not wearing	0 620		

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0 620	Continued From page 14 any shoes and was not using her walker. She reported she "just fell" in the foyer and was not sure what happened but that "my legs just gave out maybe." Resident's appearance was very disheveled, she had very short shorts on that were soiled with both urine and feces. She was confused and short of breath as well. Resident complained her arm hurt and wanted to go to the ED. EMS called and she was transported to [hospital] where she was found to have a fractured humerus. She is now at [Facility Name] nursing home receiving rehab". On January 22, 2025, at 11:50 a.m., corporate quality director (CQD)-C stated R5's MAARC report was submitted late, and the facility's policy was to report and injury with fracture immediately (within 24 hours) of the incident occurring. The licensee's Maltreatment Prohibition policy dated August 1, 2021, an accident that results in any injury must be reported internally, and possibly to the MAARC. An internal investigation must be done to determine if any neglect was involved and if a report to MAARC is necessary. If neglect or abuse is suspected a report must be filed immediately (within 14 hours). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=D	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	0 630		

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0 630	Continued From page 15 individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R2 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 R2 was admitted on December 1, 2023, with diagnoses that included diabetes. R2's service plan dated January 9, 2025, indicated R2 received services to include bathing, housekeeping, laundry, diabetic management, and medication management. On January 21, 2025, at 10:10 a.m., the surveyor	0 630		

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0 630	Continued From page 16 observed unlicensed personnel (ULP)-D administer medications to R2. R2's IAPP dated January 9, 2025, did not include the following required items: - the resident's risk of abusing other vulnerable adults - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R3 R3 was admitted on October 29, 2022, with diagnoses that included diabetes. R3's service plan dated October 22, 2024, indicated R3 received services to include bathing, TED hose (thrombo-embolic deterrent) (stockings that help prevent blood clots), housekeeping. Laundry, diabetic management and medication management. R3's IAPP dated January 9, 2025, did not include the following required items: - the resident's risk of abusing other vulnerable adults - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On January 22, 2025, at 2:08 p.m., corporate quality director (CQD)-C reviewed R2's IAPP and stated it did not include the required content as listed above. The licensee's Maltreatment Prohibition policy dated August 1, 2021, indicated an evaluation of each resident would be completed to determine areas of vulnerability to develop an Individualized Abuse Prevention Plan.	0 630		

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0 630	Continued From page 17 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 690 SS=D	144G.43 Subdivision 1 Resident record (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 observation, interview, and record review, the licensee failed to ensure entries in the resident records were authenticated by the name and title of the person making the entry for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R3 was admitted on October 29, 2022, with diagnoses that included diabetes. R3's service plan dated October 22, 2024,	0 690		

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0 690	Continued From page 18 indicated R3 received services to include medication management. On January 21, 2025, at 1:01 p.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R3. R3's Medication Administration Record (MAR) for Medication Setup dated January 2025, included staff initials but lacked staff names/signatures and credentials/title. On January 23, 2025, at 9:15 a.m., corporate quality director (CQD)-C stated R3's MAR did not include staff names/signatures and credentials/titles. The licensee's Documentation of Medications, Treatment and Therapy Management Services policy, undated, indicated: -Documentation would follow professional standards for documentation which included: -authenticated with the name and title of the person making the entry. When initials are used by persons making entries in the resident record, the person will authenticate initials with a full signature and title. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 730 SS=D	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	0 730		

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0 730	Continued From page 19 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 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	0 730		

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0 730	Continued From page 20 (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 interview and record review, the licensee failed to ensure one of one discharged resident's record (R4) included a discharge summary with the required content. 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: R4 was admitted to the licensee on October 29, 2022, and discharged on October 31, 2024. R4's discharge summary dated October 24, 2024, failed to include: - a summary of the resident's stay that includes allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; - a final summary of the resident's status from the latest assessment or review under Minnesota Statues, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; - reconciliation of all predischarge medications with the resident's postdischarge prescribed and over-the-counter medications; and - postdischarge plan that is developed with the	0 730		

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0 730	Continued From page 21 resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The postdischarge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any postdischarge medication and nonmedical services the resident will need. On January 22, 2025, at 2:10 p.m., corporate quality director (CQD)-C stated R4's discharge summary did not include the content as listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. 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	0 775		

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0 775	Continued From page 22 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 January 22, 2025, at 2:40 p.m., the surveyor toured the facility with environmental services director (ESD)-G, corporate quality director (CQD)-C, and quality consultant (QC)-H. During the facility tour, the surveyor observed the following: 1. In occupied resident room 102, when ESD-G attempted to open the egress window, the window handle spun freely and did not engage to allow the window to be opened by turning the handle. During the tour interview, ESD-G stated the handle mechanism was stripped and required repair. 2. In occupied resident room 204, the egress window operator arm broke when the window was opened by ESD-G. During the tour interview, ESD-G stated the window required repair. 3. Carbon monoxide alarms were not observed in resident rooms. During the tour interview, ESD-G stated carbon monoxide detectors were not installed as part of the fire alarm system and carbon monoxide alarms were not installed in resident rooms. All required carbon monoxide detectors are required to be installed between each source of carbon monoxide and tied into the building fire alarm system. When carbon monoxide alarms are not tied into the building fire alarm system, carbon monoxide alarms are required to be installed within ten feet of all sleeping rooms. 4. Emergency lights did not work when tested by ESD-G in the following locations: - By the east exit door on the main floor. - On the wall at the top of the stairs on the second	0 775		

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0 775	Continued From page 23 floor near the link to the care center. - In the corridor near resident rooms 201/202. - At the end of the corridor on the 3rd floor. All emergency lights must be maintained in operable condition to ensure sufficient illumination will be provided during a power outage to allow the building occupants to safely evacuate. During the tour interview, ESD-G verified these emergency lights were not working and repaired repair. 5. The fire labels on the fire door frames had been painted with brown paint throughout the facility on the first, second, and third floors. Fire labels must be readily visible. During the tour interview, ESD-G stated they were not aware these fire labels were on the door frames. 6. Door closers had been removed or disconnected on laundry and trash room doors on the first, second, and third floors. Door closers had been removed or disconnected on resident room doors throughout the facility. These fire doors did not self-close and positively latch. All components of a fire door assembly must be maintained. During the tour interview, ESD-G stated the door closers were this way when they started working here and did not know why the closers had been removed or disconnected. 7. Lint had accumulated behind the clothes dryer in the third floor laundry room, creating a fire hazard. During the tour interview, ESD-G verified the above listed observation. 8. An extension cord plugged into a 3-plug outlet adapter in the bathroom was used to supply power in resident room 208. Improper use of extension cords and electrical adapters creates a fire hazard. During the tour interview, ESD-G verified the above listed observation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		

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0 790 SS=E	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 maintain portable fire extinguishers as required by statute. This deficient condition had the potential to affect a limited number of 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 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: On January 22, 2025, at 2:40 p.m., the surveyor toured the facility with environmental services director (ESD)-G, corporate quality director (CQD)-C, and quality consultant (QC)-H. During the facility tour, the surveyor observed the	0 790		

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0 790	Continued From page 25 following: 1. The annual maintenance tag attached to a portable fire extinguisher installed in the corridor on the second floor was dated August 2022. 2. The annual maintenance tag attached to the portable fire extinguisher in the basement mechanical room was dated August 2023. Portable fire extinguishers must be maintained annually by certified service personnel. 3. Monthly inspections had been recorded on the back of these expired annual maintenance tags. During the tour interview, ESD-G stated they had been recording monthly inspections on the back of these tags and had not realized these annual tags were not up to date. Monthly inspections must not be recorded on annual maintenance tags that have expired. During the tour interview, ESD-G verified these fire extinguishers had not been properly maintained. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	0 800		

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	20583	A. BUILDING: _____ B. WING _____	01/23/2025

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0 800	Continued From page 26 by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. 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 of the residents). The findings include: On January 22, 2025, at 2:40 p.m., the surveyor toured the facility with environmental services director (ESD)-G, corporate quality director (CQD)-C, and quality consultant (QC)-H. During the facility tour, the surveyor observed the following: Basement: - Ceiling tiles were water damaged in multiple locations throughout the basement. - Ceiling tiles were missing in the recycling room. - There was a hole in the ceiling and a hole in the wall behind the door in the storage room. - The light fixture at the base of the stairs did not work. During the tour interview, ESD-G verified the above listed observations. ESD-G stated the damaged and missing ciles tiles were a result of water leaks that had been repaired. Resident rooms: - The ceiling finish was peeling above the shower in rooms 102, 201, 202, 203, and 206.	0 800		

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0 800	Continued From page 27 - The filter was not installed for the ventilation hood above the stove in room 101. - One side of the bifold closet was off the track in room 105. - The covers were missing on the outdoor light fixtures for rooms 201, 301, 302, 305, and 308. - The pull cord for the ceiling fan was too short for the resident to be able to reach for turning the fan on and off in room 201. During the tour interview, ESD-G verified the above listed observations. Shared areas: - There was a hole in the wall in the nurse office. - There was a hole in the ceiling above the electrical panel in the utility closet on the second floor. - One light fixture was not working in the dining room on the second floor. - Two light bulbs did not work in the fixture above the sink in the restroom adjacent to the dining room. During the tour interview, ESD-G verified the above listed observations. ESD-G stated the light fixtures were not broken, it was just bad bulbs that needed to be replaced. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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) staff actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 28 (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) Staff 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 staff 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 develop the fire safety and evacuation plan with required content, make the plan readily available, and provide required drills. 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	0 810		

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0 810	Continued From page 29 or has potential to affect a large portion or all of the residents). The findings include: On January 22, 2025, at 5:10 p.m., the surveyor toured the facility with environmental services director (ESD)-G. The surveyor requested to see the location where the fire safety and evacuation plan (FSEP) was kept. During the tour interview, ESD-G stated the FSEP was stored in the lobby. The surveyor observed a copy of the FSEP was not maintained in this location. The FSEP was not located in a central location for all staff accessibility. ESD-G stated they did not know why the FSEP was missing. On January 22, 2025, ESD-G provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP dated March 1, 2019, was for the care center. The FSEP had not been developed and maintained for the assisted living facility. The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks for the assisted living facility. The FSEP did not identify specific fire protection actions for residents relative to the assisted living facility. The FSEP did not include specific procedures for employees and residents during the night shift, when the assisted living facility was not staffed. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs	0 810		

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0 810	Continued From page 30 of residents. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift evident by a review of completed fire drill reports lacking the required frequency. Twelve fire drills were completed in the past year. Nine drills were day shift, two evening shift, and one night shift. At least two night shift drills had not been completed in the past twelve months. During an interview on January 22, 2025, at 5:40 p.m., ESD-G verified the FSEP required revision and the night shift drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=D	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 a staff member 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 by:	01290		

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01290	Continued From page 31 Based on interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living facility's health facility identification (HFID) number for one of three employees (unlicensed personnel (ULP)-E). This had the potential to affect all residents living in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired on December 14, 2023, to provide direct care and services to the facility's residents. ULP-E's employee record contained a Background Study Clearance dated December 12, 2023, from the attached nursing home. However, ULP-E was not affiliated with the facility's license. On January 22, 2025, at 2:12 p.m., corporate quality director (CQD)-C stated ULP-E's background study was not affiliated with the facility's license. The licensee's Individual Eligibility Screening policy dated April 6, 2020, indicated the licensee would conduct required background studies on all applicable individuals in accordance with applicable federal, state and local laws, including	01290		

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01290	Continued From page 32 fair employment and equal employment opportunity practices to determine individual eligibility. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01440		

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01440	Continued From page 33 review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for three of three unlicensed personnel (ULP-D, ULP-E and ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: ULP-D ULP-D was hired on January 31, 2020, to provide direct care and services to the facility's residents. On January 22, 2025, at 8:41 a.m., the surveyor observed ULP-D administer medications to R1. ULP-D's employee record contained a Supervision of RA/LPN/RN (resident assistant/licensed practical nurse/registered nurse) document dated October 15, 2024. However, the document did not include evidence of a RN supervision of ULP-D performing delegated tasks. ULP-E ULP-E was hired on December 14, 2023, to provide direct care and services to the facility's residents. ULP-E's employee record lacked documentation	01440		

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01440	Continued From page 34 of a RN supervision ULP-E performing delegated tasks within 30 days of beginning work with the licensee. ULP-F ULP-F was hired on October 22, 2024, to provide direct care and services to the facility's residents. ULP-F's record contained a 30 Day New Hire Check-In document dated November 20, 2024. However, the document did not include evidence of a RN supervision of ULP-F performing delegated tasks. On January 22, 2025, at 1:58 p.m., clinical nurse supervisor (CNS)-B stated she did not include documentation of the delegated tasks on the 30 day supervision of all ULPs. On January 22, 2025, at 3:55 p.m., corporate quality director (CQD)-C stated ULP-D, ULP-E and ULP-F's employee records lacked documentation of a RN supervision performing delegated tasks within 30 days of beginning work with the licensee. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated August 1, 2021, indicated direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins working for our agency and has been trained and determined competent to perform all the tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		

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01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (unlicensed personnel (ULP)-E) received 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	01530		

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01530	Continued From page 36 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: The licensee provided services under an Assisted Living Facility license. ULP-E was hired on December 14, 2023, to provide direct care and services to the facility's residents. ULP-E's employee record contained evidence the employee received five and a half hours of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. On January 22, 2025, at 3:44 p.m., corporate quality director (CQD)-C reviewed ULP-E's training record and stated ULP-E's record lacked the required amount of training in dementia care. The licensee's Notice of Dementia Training for Assisted Living policy dated August 1, 2022, indicated all staff receive at least eight hours of dementia training required on orientation within 160 hours of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		

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01640	Continued From page 37	01640		
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 observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for three of three residents (R1, R2 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a	01640		

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01640	Continued From page 38 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 was admitted on December 1, 2023, with diagnoses that included diabetes and edema (swelling caused by fluid buildup in the body's tissues). On January 22, 2025, at 8:41 a.m., the surveyor observed unlicensed personnel (ULP)-D weigh R1. R1's service plan dated January 9, 2025, indicated R1 received services to include bathing, TED hose (thrombo-embolic deterrent) (stockings that help prevent blood clots), housekeeping, laundry, diabetic management, and medication management. R1's signed prescriber orders dated December 12, 2024, included: -Check weight one time per day. Dry weight is 189 pounds (lbs.) If weight is up or down more than three pounds in 24 hours or five pounds in in seven days from the 189 lbs., alert the nurse who will then call the clinic. R1's service plan did not include daily weights. R2 R2 was admitted on December 1, 2023, with diagnoses that included diabetes and edema. R2's service plan dated January 9, 2025, indicated R2 received services to include bathing,	01640		

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01640	Continued From page 39 housekeeping, laundry, diabetic management, and medication management. On January 21, 2025, at 10:10 a.m., the surveyor observed ULP-D check R2's blood pressure, pulse and take R2's weight. R2's signed prescriber orders dated June 10, 2024, included: -metoprolol Succinate ER 50 milligrams (mg); take one tablet by mouth once per day. Check blood pressure and pulse. Hold if pulse is less than 60 or systolic blood pressure is less than 90. Inform nurse if held. -Check weight one time per day. Report weight gain of two to three pounds per day or three to five pounds per week. R2's service plan did not include daily blood pressure and pulse checks, or daily weights. R3 R3 was admitted on October 29, 2022, with diagnoses that included diabetes. R3's service plan dated October 22, 2024, indicated R3 received services to include bathing, TED hose, housekeeping, laundry, diabetic management and medication management. R3's signed prescriber orders dated November 5, 2024, included: -okay to discontinue compression stockings as resident has consistently refused them for the past month. R3's service plan included TED hose services; however, R3 no longer received this service. On January 23, 2025, at 9:08 a.m., corporate	01640		

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	20583	A. BUILDING: _____ B. WING _____	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 40 quality director (CQD)-C reviewed R1, R2, and R3's service plan and stated their service plans did not accurately reflect the services provided as listed above. CQD-C further stated the nurse who prepared the service plan had not selected the correct options within the resident's assessment which is why the treatment services had not pulled through to the service plan. The licensee's Content, Development and Revision of the Service Plan policy dated August 1, 2021, indicated the service plan and any revisions must include a signature with a name, title and date of the Assisted living designee and a signature or other authentication by the resident or the resident's representative documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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 reassessment to	01710		

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01710	Continued From page 41 include all required content for two of two residents (R1 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on January 21, 2025, at 9:10 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. R1 R1 was admitted on December 1, 2023, with diagnoses that included diabetes. On January 22, 2025, at 8:41 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1. R1's service plan dated January 9, 2025, indicated R1 received services to include medication management. R1's medication administration record (MAR) dated January 2025, included the following orders: -Humalog injection solution 100 units/milliliter (ml); Inject 7 units one time per day at 8:30 a.m. (self-administered), inject 11 units every day at 12:30 p.m. (self-administered), inject 11 units	01710		

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01710	Continued From page 42 every day at 4:30 p.m. (self-administered). -Lantus Solostar solution 100 unit/ml; inject 15 units one time per day (self-administered). R1's Medication Review assessment dated December 23, 2024, indicated: - the licensee manages and administers all or some of the resident's medications. - Needs medication set-up from staff, nurse checks in all meds prior to each cycle fill; RA's (resident assistant/ULP) administer medications. R1's Medication Review did not address if R1 was assessed for self-administration of insulin. R3 R3 was admitted on October 29, 2022, with diagnoses that included diabetes. R3's service plan dated October 22, 2024, indicated R3 received services to include medication management. On January 21, 2025, at 1:01 p.m., the surveyor observed ULP-D administer medications to R3. R3's MAR dated January 2025, included the following orders: -acetaminophen 500 mg; two tablets by mouth every four hours as needed (self-administered) -melatonin 3 mg; one tablet as needed at bedtime (self-administered). R3's Medication Review assessment dated January 3, 2025, indicated - the licensee manages and administers all or some of the resident's medications. - Needs medication set-up from staff, nurse checks in all meds prior to each cycle fill; RA's administer medications.	01710		

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01710	Continued From page 43 R3's Medication Review did not address if R3 was assessed for self-administration of medications. On January 23, 2025, at 8:09 a.m., clinical nurse supervisor (CNS)-B stated assessments for self-administration of medications should be included within the resident's medication assessment and review. CNS-B stated R1 self-administered her insulin and R3 self-administered her acetaminophen and melatonin. CNS-B further stated R1 and R3's assessment did not include evidence of being assessed for self-administration of medications. On January 25, 2025, at 8:30 a.m., (after the survey was completed) CNS-B provided the surveyor with a document dated November 11, 2022, which noted the following: - "I, [name of previous registered nurse], assessed R3 [residents name] on November 11, 2022, for self-administering some of her own medications. R3 was able to successfully demonstrate taking her own meds [medications] and knew what the medications were for (Tylenol at bedtime). R3 likes to stay up late and does not want to take her Tylenol till after 11 pm. No concerns found". -CNS-B provided a second document dated December 16, 2023, which noted the following: - "Self-Administration of Medication Assessment was completed with R1 [resident name] in room 103 on December 16, 2023, by [previous registered nurse name]. R1 was able to successfully demonstrate how to check her blood sugars using the Dexcom Sensor as well as blood sugar machine. She also correctly demonstrated how to inject insulin. No concerns with resident self-administering medications".	01710		

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01710	Continued From page 44 On January 25, 2025, at 9:01 a.m., corporate quality director (CQD)-C stated an assessment for self-administration should be included in the resident's medication review assessment. CQD-C further stated medication assessments should be completed annually and with change in condition. The licensee's Medication Management Services policy dated August 1, 2021, indicated medication management services would be reviewed at least every 90 days or when the resident presents with symptoms or other issues that may be medication related. The medication management record would be current and updated when there were any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01750 SS=D	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 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	01750		

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01750	Continued From page 45 by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for one of three residents (R2) whose medication administration was delegated to unlicensed personnel (ULP). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted on December 1, 2023, with diagnoses that included diabetes. R2's service plan dated January 9, 2025, indicated R2 received services to include bathing, housekeeping, laundry, diabetic management, and medication management. R2's signed prescriber orders dated June 10, 2024, included: -albuterol sulfate 90 micrograms (mcg)/actuation; one puff by mouth twice a day -diclofenac sodium external gel 1%; apply 2 grams topically to lower back. 2 grams is approximately 2.25 inches on dosing card On January 21, 2025, at 10:10 a.m., the surveyor observed ULP-D prepare R2's medications which included an albuterol sulfate inhaler and diclofenac sodium gel. ULP-D shook the albuterol sulfate inhaler and gave the inhaler to R2 who	01750		

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01750	Continued From page 46 self-administered one puff as ordered. ULP-D did not offer or instruct R2 to rinse her mouth after administering the inhaler. ULP-D then opened a new box of diclofenac sodium gel. ULP-D stated the box did not include a dosing card and was taught that if a dosage card was not available that one gram was the length of one knuckle. ULP-D then squeezed a continuous line of gel from the bottom of her pointer finger past her knuckle to the first crease (near the tip) of the finger and applied the gel to R2's back. On January 22, 2025, at 11:10 a.m., corporate quality director (CQD)-C stated the ULP should have residents rinse their mouth after using an inhaler. CQD-C further stated the facility recently trained all ULP on the fingertip unit (FTU) method for measuring gels and creams because they did not always come with a dosage card. CQD-C stated to measure a FTU you would start at the crease of your finger and go to the tip of the finger. CQD-C stated ULP-D should not have started at the bottom of her pointer finger and instead should have started at the first crease of the finger and go up to the tip. CQD-C further stated, R2's orders for diclofenac sodium gel should have included the specific directions on how to measure using the FTU method for staff to follow. The licensee's Administration of Medications, Treatment and Therapy by Unlicensed Personnel policy dated February 15, 2022, indicated the registered nurse (RN) may delegate administration of medications, treatment and therapy if: -the RN has communicated information about the medication, treatment, or therapy to the resident and provided education if needed -before performing the procedures, the RN has	01750		

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01750	Continued From page 47 instructed the ULP in the proper methods to administer the medications, treatment and therapy and the ULP have demonstrated the ability to competently follow the procedures; -The RN had developed written, specific instruction for each resident -the RN has communicated with the ULP about the individual needs of the residents; and -the RN has documented the ULP have been trained and have demonstrated competency to follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication set up included all the required content for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a	01770		

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01770	Continued From page 48 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 January 21, 2025, at 9:10 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents, including medication set up. R3 was admitted on October 29, 2022, with diagnoses that included diabetes. R3's service plan dated October 22, 2024, indicated R3 received services to include medication management. On January 21, 2025, at 1:01 p.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R3. R3's signed prescriber orders included: -acetaminophen 500 milligrams (mg); give two tablets by mouth every four hours as needed for pain, dated April 10, 2024. -melatonin 3 mg; give 3 mg by mouth every night as needed for insomnia, dated August 14, 2024. R3's Medication Administration Record (MAR) for Medication Setup dated January 2025, included staff initials for each date of January 1, 2025, through January 27, 2025, which indicated the medication was setup by the nurse. However, it did not include documentation of the dates of the actual medication setup. On January 23, 2025, at 9:15 a.m., corporate quality director (CQD)-C stated R3's medication	01770		

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01770	Continued From page 49 setup document did not include the dates of the medication setup by the nurse. The licensee's Medication Management Services policy dated August 1, 2021, indicated when setting up or reviewing medication for later administration the nurse would document dates of medications setup or reviewed, name of medication, quantity of dose, times to be administered, route of administration and name of person completing medication setup. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
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 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.	01910		

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01910	Continued From page 50 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 medications as required for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R4 was admitted to the licensee on October 29, 2022, and discharged on October 31, 2024. R4's discharge summary dated October 24, 2024, indicated R4 received assistance with medication management, and R4's medications were given to R4's power of attorney. R4's record lacked a medication disposition record at the time of discharge to include 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. On January 22, 2025, at 9:39 a.m., corporate quality director (CQD)-C stated R4's record lacked a medication disposition record with the required content as listed above.	01910		

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01910	Continued From page 51 The licensee's Disposition or Disposal of Medications policy, undated, indicated: a. A resident's current medications that are secured or stored by our facility will be given to the resident or the resident's representative when the resident's medication management services are terminated, except that the conditions listed below must be met before controlled medications belonging to a resident will be given to the resident or the resident's representative. b. Staff will document in the resident'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		

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul
651-201-4500

Type: Full
Date: *01/21/25*
Time: 14:29:21
Report: 7962251010

Food and Beverage Establishment Inspection Report

Location:
Bridges Of Zumbrota
295 West 4th Street
Zumbrota, MN55992
Goodhue County, 25

Establishment Info:
ID #: 0037752
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5077328455
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 previously issued on 06/14/22 have NOT been corrected.

4-900 Protecting Clean Items

4-904.11A

MN Rule 4626.0965A Handle, display, and dispense all single-service and single use articles and clean utensils so that contamination of lip-contact and food-contact surfaces is prevented.

BASKET OF SINGLE-USE SPOONS, PICTURE TAKEN

REISSUED 1-21-25
Issued on: 06/14/22 *Comply By: 06/14/22*

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

CORNER IN KITCHEN EXPOSED METAL AND SHEET-ROCK, PICTURE TAKEN

REISSUED 1-21-25
Issued on: 06/14/22 *Comply By: 06/14/22*

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

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

NO TEST STRIPS FOR TESTING SANITIZER SPRAY BOTTLE

Comply By: 01/21/25

7-100 Toxic Labeling

7-102.11 ***** Priority 2 *****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

SEVERAL SPRAY BOTTLES WITH NO LABELS

Comply By: 01/21/25

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

INTERIOR OF CABINETS DUSTY AND DIRTY

Comply By: 01/24/25

4-600 Cleaning Equipment and Utensils

4-602.12

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

INTERIOR OF MICROWAVE DIRTY

Comply By: 01/21/25

4-900 Protecting Clean Items

4-904.13

MN Rule 4626.0975 Protect preset tableware from contamination by wrapping, covering or inverting. Remove exposed preset tableware that is unused when a customer is seated or clean and sanitize exposed preset tableware that is not removed when a customer is seated.

UTENSILS FOOD CONTACT SURFACES NOT ORIENTED IN ONE DIRECTION

Comply By: 01/21/25

Type: Full
Date: *01/21/25*
Time: 14:29:21
Report: 7962251010
Bridges Of Zumbrota

Food and Beverage Establishment Inspection Report

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.114AB

MN Rule 4626.1580AB Remove all items unnecessary to the operation or maintenance of the establishment and litter from the premises.

REMOVE ALL UNUSED ITEMS, INCLUDING BUT NOT LIMITED TO ELECTRIC FRY PAN, TRAYS, CROCKPOT IN OVEN

Comply By: 01/24/25

Food and Equipment Temperatures

Process/Item: Domestic Refrigerator
Temperature: 41 Degrees Fahrenheit - Location: gallon of milk
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	2	6

Establishment Info:
Email reports to:
April Rovang, RN, april.rovangjohnson@sfhs.org

1-21-24
Kitchen:
wood cabinets with enclosed base
domestic equipment
rubber cove base
linoleum floor
painted sheetrock walls
painted ceiling
wood trim
trim on counter failing

Assisted Living Kitchen:

* Served out of kitchen: breakfast, lunch, dinner, no self service meals
* Free will snacks
* Food delivered from skilled nursing kitchen
* Same day service only in this kitchen
* All dishes sent to Skilled Nursing kitchen to be washed
* Residents are not allowed in kitchen
* No cooking with stove
* Microwave used for re-heating and cooking
* Ice scoop returned to main kitchen to be cleaned after each meal
* Certified Food Protection Manager is located in nursing home kitchen
* Employee Illness log maintained by Certified Food Protection Manager in nursing home kitchen

Type: Full
Date: *01/21/25*
Time: 14:29:21
Report: 7962251010
Bridges Of Zumbrota

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7962251010 of 01/21/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
April Rovang
RN

Signed:_____
Heather Flueger
Public Health Sanitarian
Rochester District Office
507-208-3096
heather.flueger@state.mn.us