Electronically Delivered

June 21, 2022

Administrator
Gil-Mor Haven
90 3rd Street East
Morgan, MN 56266

RE: Project Number(s) SL30741015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 27, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

St. Paul, MN 55164-0970 St. Paul, MN 55164-0970

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

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30741	A. BUILDING: _____ B. WING _____	05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR HAVEN	90 3RD STREET EAST MORGAN, MN 56266

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30741015 On, May 24, 2022, through May 27, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 16 residents, all of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 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 required staffing plan was developed and posted as required, potentially affecting the licensee's current residents, staff and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a	0 470		

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0 470	Continued From page 2 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: The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the 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 On May 24, 2022, at approximately 1:40 p.m. upon arriving at the establishment, an observation was made of the main entry area and lacked the required posting of the staff schedule. On May 24, 2022, at approximately 1:49 p.m. registered nurse (RN)-A confirmed a staffing plan had not been developed or a schedule posted as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 650 SS=A	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 3 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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained all the required content for one of two employees (registered nurse (RN)-A) with records reviewed. This practice resulted in a level one violation (a	0 650		

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0 650	Continued From page 4 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: RN-A had a hire date of September 16, 2021, to provide direct care services to the licensee's residents. RN-A's employee record lacked the required content to include: - record of orientation; and - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision On May 26, 2022, at approximately 1:10 p.m. RN-A confirmed the employee record lacked the above required content. The licensee's Personnel Records policy undated indicated the licensee would keep an employee record for all paid employees. Employee records for each person will include: - record of orientation; and - a current job description, which includes qualifications, responsibilities, and identification of supervisors, if any. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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0 810	Continued From page 5	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and	0 810		

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0 810	Continued From page 6	0 810		

evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors.

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

Findings include:

A record review and interview were conducted on May 24, 2022, at approximately 3:40 p.m. with Registered Nurse (RN)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.

Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. During interview, RN-A indicated that she was not aware of the location of these provisions and that these were the responsibility of the Maintenance Manager (MM)-D who had left for the day and was not able to be reached. Records provided by email the following day by MM-D indicated that the employee actions prescribed were primarily for the attached nursing home and indicates the nursing home staff are to go the assisted living and notify residents in case of a fire. The provided plan also does identify some actions to be taken in the event of a fire for situations when multiple staff are present but

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0 810	Continued From page 7 does not indicate actions for when facility is minimally staffed with one employee overnight. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, RN-A indicated that she was not aware of the location of these provisions and that these were the responsibility of the Maintenance Manager (MM)-D who had left for the day and was not able to be reached. Records provided by email the following day by MM-D indicated the fire safety and evacuation plan lacked fire protection procedures for resident. Record review of the available documentation indicated that the licensee did not have a fire safety and evacuation plan that was readily available at all times within the facility. During interview, RN-A was not able to provide the fire safety and evacuation plan upon request and indicated that the plan location was the responsibility of the Maintenance Manager (MM)-D who had left for the day and was not able to be reached. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. During interview, RN-A indicated that she was not aware of the location of the required documentation or polices and that these were the responsibility of the Maintenance Manager (MM)-D who had left for the day and was not able to be reached. Records provided by email the following day by MM-D lacked any documentation or a policy indicating that employees receive training on the fire safety and evacuation plan for	0 810		

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0 810	Continued From page 8 the facility. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, RN-A indicated that she was not aware of the location of the required documentation or polices and that these were the responsibility of the Maintenance Manager (MM)-D who had left for the day and was not able to be reached. Records provided by email the following day by MM-D lacked documentation or a policy indicating that residents who are capable of self-evacuation receive training on the actions to be taken in a fire or similar emergency. Record review of the available documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. During interview, RN-A indicated that she was not aware of the location of the required documentation and that these were the responsibility of the Maintenance Manager (MM)-D who had left for the day and was not able to be reached. Records provided by email the following day by MM-D indicated that only one fire drill was performed on August 31, 2021 but did not specify that any evacuation protocols were performed. No further drill documentation was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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01530	Continued From page 9	01530		
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 two employees (registered nurse (RN)-A) received the required amount of dementia care training, in the required time frame in accordance with 144G.64 with records reviewed. This practice resulted in a level two violation (a	01530		

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01530	Continued From page 10 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-A's record lacked documentation of the required eight hours of dementia training within 120 working hours of the employment start date. RN-A's hire date was September 16, 2021, and had worked more than 120 hours. RN-A's record included completion dated February 26, 2022, for successful completion of "Dementia a Refresher" for "one credited hour." On May 26, 2022, at approximately 1:10 p.m. RN-A stated she did not complete eight hours of dementia training and had completed one hour since hire date. In addition, stated she worked 40 hours every week and provided direct care to the residents. The licensee's Dementia Training policy undated, identified supervisors of direct care staff will complete a minimum of eight hours of training to be completed within 120 hours working hours of the employment start date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01640	Continued From page 11	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. (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 services were provided as required by the service plan for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01640		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR HAVEN	90 3RD STREET EAST MORGAN, MN 56266

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 12 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 May 24, 2022, at approximately 1:40 p.m. during the entrance conference, registered nurse (RN)-A stated the licensee's medications were set up weekly in a medication planner by unlicensed personnel (ULP)-F. In addition, the medications set-up in the planner were verified by RN-A, and documented by RN-A on the medication administration record. R1 R1's service plan dated April 28, 2022, indicated R1's services included whirlpool bath, medication set-up, and medication administration. On May 25, 2022, at approximately 12:04 p.m. ULP-B was observed to administer oral medications to R1. R1's medication administration record for May 2022, included medication set-up on dates of May 3, 10, 17, 24, and May 31, 2022, documented by RN-A. R1's Care Plan dated January 13, 2020, included services will be implemented per tenant's rental agreement and service contract. R1's Client Individualized Mediation Management Plan dated August 5, 2021, indicated medication set-up weekly completed on Tuesdays by the licensee's RN/licensed practical nurse (LPN).	01640		

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01640	Continued From page 13 R2 R2's service plan dated April 28, 2022, indicated R2's services included review of blood sugars, medication set-up, medication administration, daily blood sugar check reminders, blood pressure and pulse check. On May 25, 2022, at approximately 12:20 p.m. ULP-B was observed to administer oral medications to R2. R2's medication administration record for May 2022, included medication set-up on dates of May 3, 10, 17, 24, and May 31, 2022, documented by RN-A. R2's Care Plan dated August 27, 2014, included services will be implemented per tenant's rental agreement and service contract. R2's Client Individualized Mediation Management Plan dated March 11, 2021, indicated medication set-up weekly completed on Tuesdays by the agency's RN. On May 25, 2022, at approximately 12:32 p.m. RN-A stated R1's and R2's medications were set-up weekly by unlicensed personnel. After the medications were set-up, RN-A verified the medications set-up in medication planner and documented completion of task on medication administration record. The licensee's Service Plan policy undated, indicated the licensee will implement and provided all services indicated on the current service plan. No further information was provided.	01640		

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01640	Continued From page 14 TIME PERIOD FOR CORRECTION: Seven (7) days	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 review, the licensee failed to ensure the service	01650		

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01650	Continued From page 15	01650		

plan included the required content for two of two residents (R1, R2) with records reviewed.

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

R1 and R2's service plans lacked the schedule and method of monitoring assessments of the resident and the schedule and methods of monitoring staff providing services.

R1
On May 25, 2022, at approximately 12:04 p.m. unlicensed personnel (ULP)-B was observed to administer oral medications to R1.

R1's service plan dated April 28, 2022, indicated R1's services included whirlpool bath, medication set-up, and medication administration.

R1's Service Plan dated April 28, 2022, lacked the required content noted above.

R2
On May 25, 2022, at approximately 12:20 p.m. ULP-B was observed to administer oral medications to R2.

R2's service plan dated April 28, 2022, indicated R2's services included review of blood sugars, medication set-up, medication administration,

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01650	Continued From page 16 daily blood sugar check reminders, blood pressure and pulse check. R2's Service Plan dated April 28, 2022, lacked the required content noted above. On May 25, 2022, at approximately 2:50 p.m. registered nurse (RN)-A confirmed the service plan did not include the correct schedule of monitoring assessments of the resident, and lacked the schedule and methods of monitoring staff providing services. In addition, RN-A stated the same format would be utilized for all residents. The licensee's Contents of Service Plans policy undated, noted the service plan would include the schedule and methods of monitoring reviews or reassessments of the resident, and the schedule and methods of monitoring staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
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:	01710		

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01710	Continued From page 17 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed annual medication re-assessments for one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's record lacked documentation of an annual medication re-assessment. The most recent medication assessment was dated March 11, 2021, under the licensee's comprehensive home care license. On May 26, 2022, at approximately 9:25 a.m. registered nurse (RN)-A confirmed R2's record did not include the annual medication re-assessment that was due for R2 in March 2022. RN-A further stated, "I didn't know this had to be done." The licensee's Assessment for Medication & Treatment Management Program undated, indicated medication re-assessments would occur annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01710		

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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.	01730		

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01730	Continued From page 19 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individualized medication management record with the required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 On May 25, 2022, at approximately 12:04 p.m. unlicensed personnel (ULP)-B was observed to administer oral medications to R1. R1's Individualized Medication Management Plan dated August 5, 2021, lacked written procedures for staff to notify a registered nurse (RN) or appropriate licensed health professional when a problem arises. R1's service plan dated April 28, 2022, indicated medication administration was assigned to "HHA (Home Health Aide)."	01730		

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01730	Continued From page 20 R2 On May 25, 2022, at approximately 12:20 p.m. ULP-B was observed to administer oral medications to R2. R2's service plan dated April 28, 2022, indicated medication administration was assigned to "HHA (Home Health Aide)." R2's Individualized Medication Management Plan dated March 11, 2021, lacked procedures for ULP to notify a nurse if problems arise. On May 26, 2022, at 9:26 a.m. RN-A confirmed staff do not have specific instructions for notifying the RN or licensed health professional when problems arise. RN-A further stated "I didn't know" the plan was to include this. The licensee's Development of the Individualized Medication Management Plan policy dated July 1, 2014, the plan will address a procedure for staff to notify the RN (or appropriate Licensed Health Professional) when there is a problem with any medication management service. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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.	01880		

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01880	Continued From page 21 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permit only authorized personnel to have access. 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 May 26, 2022, at approximately 11:18 a.m. during a review of stored medications in the medication cart, a key in the top drawer and a key ring with keys hanging beside the medication refrigerator were observed. Unlicensed personnel (ULP)-C stated the keys hanging on the medication refrigerator were for opening the medication cart, and the key in the top drawer of the medication cart was for the narcotic box inside the medication cart. On May 26, 2022, at approximately 11:26 a.m. registered nurse (RN)-A confirmed the medication cart keys were hanging on the side of the medication refrigerator and the medications in the medication cart weren't securely locked in substantially constructed compartments, and permitted only authorized personnel to have access.	01880		

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01880	Continued From page 22 The licensee's Storage of Medications policy undated, indicated medications would be kept securely locked and stored per manufacturer's directions and only authorized staff would have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were not expired for two of two residents (R1, R2). In addition, the licensee failed to ensure medications were maintained bearing the original prescription label for one of two residents (R2) with medication cart reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	01890		

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01890	Continued From page 23 found to be pervasive). The findings include: R1's and R2's service plans dated April 28, 2022, indicated R1 and R2 received services to include medication management. On May 26, 2022, at approximately 9:00 a.m. the locked medication cart was reviewed with unlicensed personnel (ULP)-C. The following was observed and confirmed with registered nurse (RN)-A: Expired medications: R1's anti-diarrhea 2 milligrams (mg) had an expiration date of May 4, 2022. R2's Trazodone HCL 50 mg (sleep aid) had an expiration date of May 25, 2022. No prescription label: Artificial Tears Lubricant Eye drops included an opened date, but did not include a prescription label. On May 26, 2022, at approximately 9:05 a.m. ULP-C stated the medication cart was checked weekly for expired medications along with the medication set-up. On May 26, 2022, at approximately 9:10 a.m. RN-A verified all of the findings listed above. The licensee's Storage of Medications policy undated, indicated the prescription drug must be kept in the original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quality of drug, expiration date of time-dated drug, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. In addition, the policy indicated medications will be handled, stored per acceptable standard and according to manufacturer's recommendations.	01890		

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01890	Continued From page 24 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 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 medications, 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 for one of one discharged resident	01910		

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01910	Continued From page 25 (R3) with record review. 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: R3 admitted to the licensee on June 12, 2021. R3's diagnoses included transient ischemic attack (TIA). R3's Service Plan dated April 25, 2022, identified R3 received services of medication set-up weekly, medication administration, meals, laundry, and housekeeping. R3 was discharged from the licensee on April 25, 2022. R3's record lacked documentation of a disposition of medications upon discharge. On May 10, 2022, at approximately 11:18 a.m. registered nurse (RN)-A confirmed the licensee did not complete a disposition of medications upon R3's discharge. The licensee's Disposition or Disposal of Medication's policy undated, indicated 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 the medication remaining. No further information was provided.	01910		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR HAVEN	90 3RD STREET EAST MORGAN, MN 56266

(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
01910	Continued From page 26 TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02240 SS=C	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. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail 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, e-mail, telephone number, and name or title of the	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30741	A. BUILDING: _____ B. WING _____	05/27/2022

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02240	Continued From page 27	02240		

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 for two of two residents (R1, R2) with records reviewed.

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 and R2 began receiving services under the assisted living licensure on August 1, 2021.

R1 and R2's record did not contain written acknowledgement of receipt of the current Assisted Living Bill of Rights dated May 16, 2021.

On May 25, 2022, at approximately 3:04 p.m. registered nurse (RN)-A confirmed R1 and R2 had not received the current bill of rights dated

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	30741	A. BUILDING: _____ B. WING _____	05/27/2022

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02240	Continued From page 28 May 16, 2021, or a written acknowledgement was received. RN-A further stated the bill of rights was usually given at admission, but did not recall R1 and R2 being updated with newest version. The licensee's Notice of Resident Rights policy undated, indicated before receiving services, residents have the right to be informed by the facility of the rights granted under this section and the recourse residents have if violated. The policy lacked direction to ensure written acknowledgement of receipt of the current assisted living bill of rights was obtained. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02310 SS=F	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the care and services according to acceptable health care, medical, or nursing standards for two of two residents (R1, R2) with medication set up by unlicensed personnel with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30741	A. BUILDING: _____ B. WING _____	05/27/2022

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02310	Continued From page 29	02310		

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 May 24, 2022, at approximately 1:40 p.m. during the entrance conference, registered nurse (RN)-A stated the licensee's medications were set up weekly in a medication planner by an unlicensed personnel (ULP)-F. In addition, the medications set-up in the planner are verified by RN-A and documented by RN-A on the medication administration record.

R1
ULP-F completed medication setup for later administration for R1.

R1's diagnoses included essential hypertension (high blood pressure) and dementia.

R1's service plan dated April 28, 2022, indicated the resident received services which included medication administration.

R1's prescriber's orders dated May 21, 2022, included an order for two anti-hypertensives, one anti-convulsant, one diuretic and one anti-diarrhea.

On May 25, 2022, at approximately 12:04 p.m. ULP-B was observed to administer oral medications to R1. ULP-C stated ULP-F set up R1's medication planner weekly.

On May 26, 2022, at 11:23 a.m., RN-A stated documentation of medication set-up included her

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	30741	A. BUILDING: _____ B. WING _____	05/27/2022

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02310	Continued From page 30 initials on the medication administration record for the dates of May 3, 10, 17, 24, and May 31, 2022, indicating the medication planner was verified by RN-A. R2 ULP-F completed medication setup for later administration for R2. R2's diagnoses included essential hypertension, and type 2 diabetes. R2's service plan dated April 28, 2022, indicated the resident received services which included medication administration. R2's prescriber's orders dated May 3, 2022, included an order for two anti-hypertensives, one anti-inflammatory, one cholesterol lowering, two vitamins, one antidepressant, one thyroid, one chemotherapy, one anti-convulsant, three anti-nausea, one hypoglycemic and two pain medications. On May 25, 2022, at approximately 12:20 p.m. ULP-B was observed to administer oral medications to R2. On May 26, 2022, at 11:23 a.m. RN-A stated documentation of medication set-up included her initials on the medication administration record for the dates of May 3, 10, 17, 24, and May 31, 2022, indicating the medication planner was verified by RN-A. On May 26, 2022, at approximately 1:10 p.m. RN-B confirmed it was not an acceptable practice for ULP to setup medications for later administration.	02310		

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02310	Continued From page 31 According to the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making. MN Statute 144G.08, Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *05/26/22*
Time: 12:00:05
Report: 1028221097

Food and Beverage Establishment Inspection Report

Location:
Gil-Mor Haven
90 3rd Street East
Morgan, MN56266
Redwood County, 64

Establishment Info:
ID #: 0038171
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072493143
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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

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

This Inspection was conducted in conjunction with HRD.

All food is prepared and catered in from the Nursing Home kitchen.

Dishes, equipment, and utensils are cleaned and sanitized in the Nursing Home kitchen.

Type: Full
Date: *05/26/22*
Time: 12:00:05
Report: 1028221097
Gil-Mor Haven

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 Dept. of Health inspection report number 1028221097 of 05/26/22.

Certified Food Protection Manager: N/A

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____

Terea Vogl
TMA

Signed: _____

Ryan Miller
Environmental Health Spec. II
Mankato
Ryan.Miller@state.mn.us