DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 22, 2022

Administrator
D & D's Caring Hearts
1426 Pamela Court Northwest
Bemidji, MN 56601

RE: Project Number(s) SL33601015

Dear Administrator:

On September 16, 2022, the Minnesota Department of Health completed a follow-up evaluation of your c to determine if orders from the June 29, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

PMB

Electronically Delivered

July 7, 2022

Administrator
D & D's Caring Hearts
1426 Pamela Court Northwest
Bemidji, MN 56601

RE: Project Number(s) SL33601015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 29, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500
St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000

The total amount you are assessed is $3,500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general Free from Maltreatment reconsideration

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

Jessie Chenze, RN, BSN
Interim HFE Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-51751 | Mobile: 651-508-2791| Fax: 218-332-5196

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33601	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D & D'S CARING HEARTS	1426 PAMELA COURT NW BEMIDJI, MN 56601

(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#33601015 On, June 27, 2022, through June 29, 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 ten residents, all of whom received services under the provider's Assisted Living license. An immediate correction order was identified on June 27, 2022, issued for SL33601015, tag identification 2310. On June 28, 2022, the immediacy of the correction order 2310 was removed, however, non-compliance remained at a patterned scope, level three (H).	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.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content for one of one resident (R2) with records reviewed. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 430		

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0 430	Continued From page 2 The findings include: R2's diagnoses included diabetes, hypertension, overactive bladder, and osteoarthritis. R2's service plan dated March 15, 2021, indicated the resident received services which included medication administration, bathing, hygiene/grooming, dressing, toileting, laundry, and housekeeping. R2's record lacked evidence the resident received a copy of the licensee's UDALSA to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. On June 28, 2022, at 9:53 a.m., registered nurse (RN)-A stated she was unfamiliar with the UDALSA. RN-A confirmed R2, and all other current residents, did not receive a copy of the UDALSA when the licensee converted to an assisted living licensure on August 1, 2021. The licensee lacked updated policies to include the new Assisted Living Licensure requirements effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		

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0 470	Continued From page 3	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 interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all ten residents.	0 470		

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0 470	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for a capacity of 14 residents and had a current census of ten residents. During the entrance conference on June 27, 2022, at 11:10 a.m., registered nurse (RN)-A was identified as the clinical nurse supervisor. RN-A and owner (O)-B stated the usual staffing schedule for the facility was as follows: - the RN was on site Monday through Friday for about four hours a day - O-B was usually on site during the daytime Monday through Friday - the day shift was staffed with one unlicensed personnel (ULP) from 7:00 a.m. to 6:00 p.m. - the night shift was staffed with one ULP from 6:00 p.m. to 7:00 a.m. On June 27, 2022, at 11:28 a.m., the surveyor asked to see the facility's staffing plan. RN-A stated she had not developed a staffing plan. RN-A stated she was unaware a staffing plan was required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 470		

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0 470	Continued From page 5 (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food	0 480		

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0 480	Continued From page 6 and Beverage Establishment Inspection Report dated June 27, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19 regarding screening of visitors and wearing appropriate personal protective equipment (PPE). This had the potential to affect all ten 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	0 510		

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0 510	Continued From page 7	0 510		

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:

VISITOR SCREENING
The Minnesota Department of Health (MDH) document titled COVID-19 Guidance: Long-term Care Indoor Visitation for Nursing Facilities and Assisted Living Type Settings, dated June 17, 2022, indicated visitors who have a positive viral test for COVID-19 or symptoms of COVID-19, or who currently meet standards for quarantine should not enter the facility until they meet standards to end quarantine, isolation, or do not have symptoms. Facilities should screen all who enter for criteria that would exclude someone from visiting.

On June 27, 2022, at 11:10 a.m., the surveyor entered the facility and was greeted by registered nurse (RN)-A and owner (O-B). RN-A and O-B did not require the surveyor to conduct a COVID-19 screening upon entry into the facility.

On June 27, 2022, at 11:30 a.m., a Minnesota Department of Health (MDH) Sanitarian entered the facility and was not required to conduct a COVID-19 screening upon entry into the facility.

On June 28, 2022, at 6:45 a.m., the surveyor entered the facility and was greeted by O-B. O-B did not require the surveyor to conduct a COVID-19 screening upon entry into the facility.

On June 28, 2022, at 10:33 a.m., the MDH Engineering Specialist and Fire Marshal entered the facility and were not required to conduct a

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0 510	Continued From page 8 COVID-19 screening upon entry into the facility. On June 28, 2022, at 12:53 p.m., RN-A stated they stopped screening visitors and taking temperatures recently because the COVID-19 rate had decreased. RN-A stated the facility tries to follow the CDC (Centers for Disease Prevention and Control) and MDH guidelines, but it is hard because they seem to keep on changing. RN-A stated they have a sign posted on the door with the common symptoms and ask visitors to not visit if they are not feeling well. PPE The MDH guidance titled, COVID-19 Personal Protective Equipment (PPE) and Source Control Grids dated April 7, 2022, indicated health care workers working with residents with or without suspected or confirmed SARS-CoV-2 (Covid-19) wear a face mask and eye protection in communities with substantial and high community transmission levels. On June 27, 2022, at 11:10 a.m., the surveyor observed upon entrance to the facility RN-A and O-B wearing a medical grade face mask but no eye protection. On June 27, 2022, at 1:48 p.m., the surveyor observed unlicensed personnel (ULP)-C to administer R2's scheduled afternoon medications. At 1:50 p.m., the surveyor observed ULP-C to administer R1's scheduled afternoon medications. The surveyor observed ULP-C to not be wearing eye protection. On June 28, 2022, at 8:30 a.m., the surveyor observed ULP-D to administer R4's scheduled medications which included an eye drop and oral medications. The surveyor observed ULP-D to	0 510		

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0 510	Continued From page 9 not be wearing eye protection. On June 28, 2022, at 12:55 p.m., RN-A and O-B stated they have not required their staff to wear eye protection since March. RN-A and O-B were not familiar with the PPE Grid referenced above. RN-A and O-B reviewed with the surveyor the facility's county transmission level on the computer. RN-A and O-B stated the current county transmission level was high, so according to the PPE Grid staff should be wearing eye protection when working with residents with or without suspected or confirmed COVID-19. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to	0 550		

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0 550	Continued From page 10 the grievance procedure. This had the potential to affect all current 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 June 27, 2022, at 11:50 a.m., the surveyor toured the facility with registered nurse (RN)-A, and observed the main entrance and/or common areas lacked the required posting for the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. On June 27, 2022, at 11:59 a.m., RN-A confirmed the licensee's grievance procedure was not posted as required. RN-A stated she thought it was posted on the medication room door with the other postings, but it was not. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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0 680	Continued From page 11 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 680		

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0 680	Continued From page 12 of the residents). The findings include: During the entrance conference on June 27, 2022, at 11:10 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided to and later reviewed by the surveyor. The licensee's EPP plan provided to the surveyor was a one-page document which provided basic direction for the staff to follow in the case of a thunderstorm watch, thunderstorm warning and fire. The licensee's EPP lacked the following: - a completed risk assessment; - policies and procedures to address natural and man-made disasters - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a missing resident plan that was reviewed quarterly (last reviewed October 18, 2017); - arrangements/contracts to re-establish utility services; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems); - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated;	0 680		

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0 680	Continued From page 13 - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families. On June 28, 2022, at 12:52 p.m., registered nurse (RN)-A stated she was familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] state operations manual which includes the emergency preparedness guidelines). Owner (O)-B stated she was not familiar with Appendix Z. After a brief review of the components required in an EPP by the surveyor, RN-A and O-B stated the facility's	0 680		

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0 680	Continued From page 14 emergency preparedness plan/program had not been fully developed as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (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	0 810		

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0 810	Continued From page 15 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, document review, and interview, the licensee failed to provide the required plans, training, and drills for fire safety and evacuation. This had the potential to directly affect all residents and staff. 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 June 28, 2022, between 10:30 a.m. and 11:15 a.m., survey staff toured the facility with the owner (O)-B. During the facility tour, it was observed that the location and number of resident sleeping rooms were not identified on the posted evacuation maps. In an interview with the O-B during the tour, they confirmed that the resident sleeping rooms were not labeled on the maps. On June 28, 2022, at approximately 11:15 a.m., the O-B provided documents for review. Documents were reviewed by survey staff on June 28, 2022, between 11:15 a.m. and 11:45 a.m. 1. The fire safety and evacuation plans failed to include: a. the location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 16 b. the identification of unique or unusual resident needs for movement or evacuation. 2. Employee training records for fire safety and evacuation were requested but not provided. 3. Documentation on resident training for fire safety and evacuation was requested but not provided. 4. Fire Drill and Alarm records were provided. Evacuation drills were completed on 09-07-21, 02-01-22, and 05-01-22. The evacuation drill frequency did not meet the twice per year per shift with at least one evacuation drill every other month frequency requirement. On June 28, 2022, at approximately 11:45 a.m., the O-B confirmed during an interview that the fire plans required revision. They also confirmed that the training and evacuation drill frequency were not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable.	0 900		

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0 900	Continued From page 17 (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for one of one resident (R2) with records reviewed. This had the potential to affect all residents. 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	0 900		

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0 900	Continued From page 18 or has the potential to affect a large portion or all of the residents). The findings include: R2's diagnoses included diabetes, hypertension, overactive bladder, and osteoarthritis. R2's service plan dated March 15, 2021, indicated the resident received services which included medication administration, bathing, hygiene/grooming, dressing, toileting, laundry, and housekeeping. R2's records lacked a written contract which included all of the terms concerning the provisions of the following as required: (1) housing (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable In addition, R2's records lacked evidence that the contract had been fully executed as the facility must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated representative. On June 28, 2022, at 12:37 p.m., owner (O)-B stated she had not developed an assisted living	0 900		

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0 900	Continued From page 19 contract when the licensee converted to an assisted living licensure on August 1, 2021. O-B stated she was not familiar with what items needed to be included in the assisted living contract and confirmed R2, and all other current residents, did not have an assisted living contract. The licensee lacked updated policies to include the new Assisted Living Licensure requirements effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."	0 950		

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0 950	Continued From page 20 (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing for one of one resident (R2) with records reviewed. This had the potential to affect all ten residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2's diagnoses included diabetes, hypertension, overactive bladder, and osteoarthritis. R2's service plan dated March 15, 2021, indicated the resident received services which included medication administration, bathing, hygiene/grooming, dressing, toileting, laundry, and housekeeping. R2's record lacked evidence of a notice with the	0 950		

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0 950	Continued From page 21 required statutory language for the resident to identify a designated representative or documentation that R2 declined to name a designated representative. On June 28, 2022, at 12:40 p.m., registered nurse (RN)-A and owner (O)-B stated they were unaware of this regulation and that none of the residents at the facility had been provided the opportunity to identify a designated representative. The licensee lacked updated policies to include the new Assisted Living Licensure requirements effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
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	01530		

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01530	Continued From page 22 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 observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-D) received the required amount of dementia care training in the required time frame with records reviewed. This had the potential to affect all residents. 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 finding include: ULP-D was hired on April 25, 2022, to provide direct care services to the licensee's residents. On June 28, 2022, at 8:30 a.m., the surveyor observed ULP-D to administer R4's scheduled medications which included an eye drop and oral	01530		

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01530	Continued From page 23 medications. ULP-D's employee records did not indicate a total of 8 hours of the required dementia training was completed within 160 hours of the employee's start date. ULP-D's employee record indicated the employee had completed 5.50 hours of dementia training. On June 28, 2022, at 12:22 p.m., owner (O)-B reviewed ULP-D's education transcript and employee records and stated she must have counted a couple of classes twice and confirmed ULP-D had only completed 5.50 hours of dementia training. O-B stated ULP-D had worked greater than 160 hours since her start date. The licensee's undated Dementia Care Training for Home Care Employees/Staff Providing Services in Housing with Services Establishments with Dementia Programs and/or Assisted Living Services policy noted supervisors or direct care staff hired January 1, 2016, or later will have at least eight hours of initial training within 120 hours of employment start date. [The licensee lacked updated policies to include the new Assisted Living Licensure requirements effective August 1, 2021]. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days	01620		

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01620	Continued From page 24	01620		

after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.
(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool for ongoing 90-day assessments for one of one resident (R2) as required with records reviewed.

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

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01620	Continued From page 25 of the residents). The findings include: R2's diagnoses included diabetes, hypertension, overactive bladder, and osteoarthritis. R2's service plan dated March 15, 2021, indicated the resident received services which included medication administration, bathing, hygiene/grooming, dressing, toileting, laundry, and housekeeping. On June 27, 2022, at 1:48 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R2 her scheduled afternoon medication. R2's record included Client Monitoring Visit Notes and a corresponding Nursing Note dated September 30, 2021, December 24, 2021, and March 30, 2021. These assessments indicated the services were appropriate to meet the resident's needs and that there were no problems or concerns noted by the resident or family. The nursing notes elaborated a bit more to cover the resident's status and reviewed some of the resident's services being provided. These assessments did not include all the elements on the uniform assessment tool as required. On June 28, 2022, at 9:52 a.m., RN-A stated she was unfamiliar with the universal assessment tool and the elements this tool covered. RN-A stated she had been documenting the 90-day assessments on the Client Monitoring Visit Notes and then writing a Nursing Note. RN-A stated she had not implemented the universal assessment tool for conducting resident assessments for any of the residents at the facility.	01620		

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01620	Continued From page 26 The licensee's Initial and On-Going Nursing Assessment of Clients Under the Comprehensive License and Agency policy dated November 1, 2017, noted the RN would reassess each client on an on-going basis and would revise the client's service plan based on clients needs. The RN would determine the frequency of re-assessment based on client's needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. [The licensee lacked updated policies to include the new Assisted Living Licensure requirements effective August 1, 2021]. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;	01730		

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01730	Continued From page 27 (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed 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 annually review the individualized medication management plan for one of one resident (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 an isolated scope (when one or a limited number of residents are affected or one or	01730		

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01730	Continued From page 28 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 27, 2022, at 11:16 a.m., registered nurse (RN)-A and owner (O)-B stated the licensee provided medication management services to residents at the facility. R2's diagnoses included diabetes, hypertension, overactive bladder, and osteoarthritis. R2's service plan dated March 15, 2021, indicated the resident received medication management services which included medication administration and medication setup. R2's prescriber orders dated March 14, 2022, included the following medications: two antihypertensive medications, one blood thinner, one vitamin supplement, one bladder relaxant, one mild pain reliever, one sedative, one insulin, one medication to treat nerve pain, and one muscle relaxant. On June 27, 2022, at 1:48 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R2 her scheduled afternoon medication. R2's most recent medication management plan included all the required content and was dated March 15, 2021 (105 days overdue for an annual review). On June 28, 2022, at 9:57 a.m., RN-A stated medication management plans should be reviewed annually. RN-A stated it had been over	01730		

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01730	Continued From page 29 12 months since R2's medication management plan had been reviewed. The licensee lacked updated policies to include the new Assisted Living Licensure requirements effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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	01910		

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licensee failed to provide documentation in the resident's record regarding the disposition of all medications to include the medication strength, prescription number, and quantity for all medications for one of one discharged resident (R3) 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 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 for services on October 1, 2021, and discharged on May 27, 2022.

R3's service plan dated October 1, 2021, indicated the resident received medication management services which included medication administration and medication setup.

R3's Discharge Summary dated May 28, 2022, indicated R3 had died on May 27, 2022, and the medications had been destroyed in the drug buster (a container that uses activated charcoal to quickly neutralize the active ingredients in pills, liquids, controlled substances and transdermal patches to break down non-hazardous pharmaceuticals).

R3's medication administration record (MAR) dated May 2022, included the following medications: Aspirin EC 81 milligrams (mg) daily, lisinopril 5 mg daily (to treat high blood pressure),

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natural fiber powder 1 teaspoon daily, prosight one tablet daily (vitamin/mineral supplement), Zoloft 25 mg daily (antidepressant), vitamin B-12 1000 micrograms (mcg) daily, metoprolol tartrate 12.5 mg twice a daily (to treat high blood pressure), Lasix 20 mg once daily as needed for wight gain of two pounds/24 hours or five pounds/week (diuretic), quetiapine 25 mg at bedtime (antipsychotic), Tylenol extra strength 500 mg every six hours for pain when needed, and morphine sulfate 2 mg every two hours as needed for severe pain.

R3's prescriber orders dated October 14, 2021, January 12, 2022, and verbal order obtained on February 15, 2022, included the above noted medications.

R3's Record of the Inventory and Destruction of Controlled and Uncontrolled Substances initially dated April 9, 2022, identified the medications R3 had been receiving at the time of her death and which had been destroyed upon her discharge to include the following: Lasix, quetiapine, lisinopril, metoprolol tartrate, Zoloft, fiber powder and morphine sulfate. The documented disposition included the medication name, strength, prescription number, quantity, and included two witness signatures (registered nurse/RN-A and owner-B).

R3's record lacked documentation for the disposition of the following medications Aspirin EC, prosight, vitamin B-12, and Tylenol as identified on R3's MAR and prescriber orders noted above to include the medication 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.

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01910	Continued From page 32 On June 27, 2022, at 12:53 p.m., RN-A stated she thought the Aspirin EC and prosight, medications had been given to R3's daughter; the vitamin B-12 they may have been out of; and she was unsure of what happened to the Tylenol. RN-A stated these medications had not been documented on the disposition log as required. The licensee's Disposition or Disposal of Medication policy dated November 4, 2017, noted staff will document the disposition or disposal of medications in the resident's record. Medications that are given to the resident or the resident's representative should be documented in the resident's record the name of the person to whom the medications were given, the time and date, the name of the medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be	01940		

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01940	Continued From page 33 provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (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 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:	01940		

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01940	Continued From page 34 During the entrance conference on June 27, 2022, at 11:16 a.m., registered nurse (RN)-A and owner (O)-B stated the licensee provided treatment and therapy services to residents as prescribed. R2's diagnoses included diabetes, hypertension, overactive bladder, and osteoarthritis. R2's prescriber orders dated March 14, 2022, included an order for blood glucose monitoring twice daily. R2's Treatment or Therapy Management Plan dated March 30, 2022, indicated R2 needed assistance with blood glucose monitoring twice daily. R2's Medication Administration Record (MAR) dated June 1, 2022, through June 26, 2022, indicated R2 received blood glucose monitoring twice daily. R2's record lacked an incomplete treatment plan as R2's service plan dated March 15, 2021, lacked a written statement of the treatment services the resident received to include blood glucose monitoring. On June 28, 2022, at 10:02 a.m., RN-A stated R2 had been receiving blood glucose monitoring services twice daily since she was admitted. RN-A stated R2's service plan did not include the blood glucose monitoring services the resident was receiving. RN-A stated she will need to update R2's care plan. The licensee's Treatment and Therapy Management Services policy dated July 12, 2018, noted the RN would prepare and include in the service plan a written statement of the treatment management services that would be provided to	01940		

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01940	Continued From page 35 the client. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure instructions, specified in writing, for each resident and documented those instructions in the resident's record for one of one resident (R2) who received blood glucose	01950		

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01950	Continued From page 36 monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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's diagnoses included diabetes, hypertension, overactive bladder, and osteoarthritis. R2's prescriber orders dated March 14, 2022, included an order for blood glucose monitoring twice daily. R2's Treatment or Therapy Management Plan dated March 30, 2022, indicated R2 needed assistance with blood glucose monitoring twice daily. R2's Medication Administration Record (MAR) dated June 1, 2022, through June 26, 2022, directed for blood glucose checks to be completed two times a day (8:00 a.m. and 5:00 p.m.). R2's MAR indicated blood glucose checks had been completed twice daily during this time frame with results ranging from 80 to 386 milligrams (mg)/deciliter (dL). R2's record lacked specific written instructions for blood glucose monitoring to include parameters for evaluation of results. On June 28, 2022, at 10:04 a.m., registered	01950		

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01950	Continued From page 37 nurse (RN)-A stated R2's record did not include specific instructions with regards to blood glucose parameters and instructions of when the unlicensed personnel/ULP would notify the RN. The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders dated November 4, 2017, indicated the treatment order must contain information needed to administer the treatment or therapy and any parameter or instructions to hold or modify the therapy if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
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	02240		

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02240	Continued From page 38 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 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 to the resident and a written acknowledgement received for one of one resident (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	02240		

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	33601	A. BUILDING: _____ B. WING _____	06/29/2022

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D & D'S CARING HEARTS	1426 PAMELA COURT NW BEMIDJI, MN 56601

(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
02240	Continued From page 39 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee was licensed as an Assisted Living facility on August 1, 2021. R2's diagnoses included diabetes, hypertension, overactive bladder, and osteoarthritis. R2's service plan dated March 15, 2021, indicated the resident received services which included medication administration, bathing, hygiene/grooming, dressing, toileting, laundry, and housekeeping. R2's record included an acknowledgement dated March 15, 2021, that the resident had received the Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers dated January 2014. On June 28, 2022, at 9:40 a.m., registered nurse (RN)-A stated she was unaware there had been an updated Bill of Rights and the licensee had not provided the residents or their representatives with this updated Bill of Rights. The licensee's Home Care Bill of Rights policy dated October 16, 2017, noted the agency would ensure that each client received a copy of the Home Care Bill of Rights that was current and applicable to the agency's services. [The licensee lacked updated policies to include the new Assisted Living Licensure requirements effective August 1, 2021]. No further information was provided.	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33601	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D & D'S CARING HEARTS	1426 PAMELA COURT NW BEMIDJI, MN 56601

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02240	Continued From page 40 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02310 SS=H	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 care and services according to acceptable health care, medical, or nursing standards for two of two residents (R1, R2) with bedrails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). This resulted in an immediate correction order on June 27, 2022, at approximately 3:10 p.m. The findings include: R1 On June 27, 2022, at 1:48 p.m., the surveyor observed R1 seated in her recliner in her room.	02310		

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	33601	A. BUILDING: _____ B. WING _____	06/29/2022

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D & D'S CARING HEARTS	1426 PAMELA COURT NW BEMIDJI, MN 56601

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02310	Continued From page 41 R1's hospital bed had bilateral upper bedrails secured to the bed. R1's diagnoses included, congested heart failure (CHF- a chronic condition in which the heart doesn't pump blood as well as it should), arthritis, hypertension, anxiety and chronic pain syndrome. R1's service plan dated March 16, 2020, indicated the resident received the following services, medication management, assistance with bathing, dressing, laundry and housekeeping. R1's Client Care Plan dated April 1, 2022, indicated the resident had a hospital bed and used a walker for mobility. R1's Client Monitoring Visit Notes dated April 1, 2022, had a check box marked "yes" by "Physical Devices are appropriate and installed, maintained and/or used per manufacturer's directions". R1's record lacked a bedrail assessment which included actual measurements of the entrapment zones and documentation that the resident and the resident's representative had been provided information on the risks and benefits of bedrails. On June 27, 2022, at 1:34 p.m., registered nurse (RN)-A stated she had not completed a bedrail assessment nor had a risk and benefit statement been provided to the resident and/or their representative regarding bedrails. RN-A stated R2 has had her hospital bed for about eight months, and she doesn't really use the bedrails. RN-A stated she was somewhat familiar with the zones of entrapment. On June 27, 2022, at 1:40 p.m., RN-A measured	02310		

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	33601	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D & D'S CARING HEARTS	1426 PAMELA COURT NW BEMIDJI, MN 56601

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02310	Continued From page 42	02310		

R2's bedrail with the surveyor present. The bedrail measured 3 ¾ inches tall and nine inches wide, which is in compliance with the FDA guidelines for bedrails. Pressure was placed on the bedrail and the bedrail appeared to be securely fastened to the bed.

R2
On June 27, 2022, at 1:50 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R2's scheduled medications. R2 was observed laying in her hospital bed on her back with bilateral bedrails in the upright position. R2 using the right bedrail positioned herself to the side of the bed placing pressure on the bedrail. The bedrail appeared to securely be attached to the hospital bed.

R2's diagnoses included diabetes, hypertension, overactive bladder, and osteoarthritis.

R2's service plan dated March 15, 2021, indicated the resident received the following services, medication management, assistance with dressing, hygiene, bathing, laundry and housekeeping. R2's Client Care Plan dated March 15, 2021, indicated the resident used a can or walker for ambulation and was incontinent.

R2's Client Monitoring Visit Notes dated March 30, 2022, had a check box marked "yes" by "Physical Devices are appropriate and installed, maintained and/or used per manufacturer's directions".

On June 27, 2022, at 1:53 p.m., RN-A stated R2 used the bedrails on her bed for positioning and mobility. RN-A stated she had not completed a bedrail assessment nor had a risk and benefit statement been provided to the resident and/or

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	33601	A. BUILDING: _____ B. WING _____	06/29/2022

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02310	Continued From page 43	02310		

their representative regarding bedrails. RN-A measured R2's bedrail with the surveyor present. he bedrail measured 4 ½ inches tall and 9 ¼ inches wide, for zone 3. Zone 7 measured seven inches (space between the inside surface of the headboard and the end of the mattress). Zone 7 was not in compliance with the FDA guidelines for bedrails. Pressure was placed on the bedrail and the bedrail appeared to be securely fastened to the bed.

The licensee's Assessing the Safety of Side Rails policy dated November 18, 2019, indicated the RN or licensed professional will educate the client, the client's representative and/or family members about the risks related to side rails. The RN would assess and evaluate what the client's needs are and assess to determine if the client can safely utilize the side rail/equipment and determine whether the side rail/equipment meets the FDA standards for side rails.

The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches.

The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 44 determine how best to keep the patient safe". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The immediacy was removed as confirmed by documentation, observation and review by the surveyor and evaluation supervisor on June 28, 2022, at 9:00 a.m.; however, noncompliance remains at a pattern scope and a level 3 (H).	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure signage was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all ten residents, staff, and visitors of the licensee. 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	03090		

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03090	Continued From page 45 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 27, 2022, at 11:10 a.m., the surveyor entered the facility. There was no signage posted in the entryway of the facility regarding electronic monitoring devices. On June 27, 2022, at 12:02 p.m., registered nurse (RN)-A and owner (O)-B stated the licensee currently did not have any video cameras in or around the facility. O-B stated the licensee did not have signage posted in the entryway regarding electronic monitoring as required. O-B stated she wasn't aware this was a requirement for everyone. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) day	03090		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *06/27/22*
Time: 11:56:24
Report: 3822221066

Food and Beverage Establishment Inspection Report

Location:
D&D Caring Hearts
1426 Pamela Court NW
Bemidji, MN56601
Beltrami County, 04

Establishment Info:
ID #: 0034155
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
D&D's Caring Hearts

Phone #: 2184445602
ID #: 48747

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-100 Supervision
2-102.12AMN
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
CARRIE ERICKSON'S CFPM EXPIRED THIS PAST FRIDAY. EMPLOY CFPM WITHIN 30 DAYS.
Comply By: 07/28/22

2-100 Supervision
2-102.12DMN
MN Rule 4626.0033D Post the certified food protection manager certificate.
POST CFPM NEXT TO ANNUAL STATE LICENSES.
Comply By: 07/28/22

6-100 Physical Facility Construction Materials
6-101.11A1
MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.
REPAIR FLOORING.
Comply By: 07/28/22

Surface and Equipment Sanitizers

Chlorine: = 200 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *06/27/22*
Time: 11:56:24
Report: 3822221066
D&D Caring Hearts

Food and Beverage Establishment Inspection Report

Process/Item: Re-Heating
Temperature: >165 Degrees Fahrenheit - Location: POT ROAST
Violation Issued: No

Process/Item: Upright Cooler
Temperature: <41 Degrees Fahrenheit - Location:
Violation Issued: No

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

RECEIVED 2022 WATER TEST RESULTS. CHECKED SEPTIC DRAINFIELD.

MEALS COOK TO SERVE. EGGS FULLY COOKED.

DOMESTIC NSF HIGH TEMP DISHWASHER; OWNER PROVIDED TEMP LOG SHOWING RECORDED TEMPS 160F+.

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 3822221066 of 06/27/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
Darlene Benson
Owner

Signed:_____
3822

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