DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

October 17, 2022

Administrator
Chestnut Grove
1204 West Chestnut Street
Virginia, MN 55792

RE: Project Number(s) SL20288015

Dear Administrator:

On October 13, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the August 31, 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,

Jessie Chenze, RN, BSN
Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-5175 | Mobile: 651-508-2791| Fax: 218-332-5196

PMB

Electronically Delivered

September 12, 2022

Administrator
Chestnut Grove
1204 West Chestnut Street
Virginia, MN 55792

RE: Project Number(s) SL20288015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 31, 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 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement = $3,000

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

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

The correction order documentation should include the following:

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

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

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

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

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

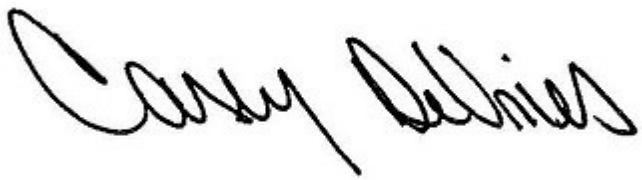
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

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

Sincerely,



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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders have been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20288015-0 On August 29, 2022, through August 31, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were 18 residents receiving services under the Assisted Living with Dementia license. An immediate correction order was identified on August 30, 2022, issued for SL20288015-0, tag identification 2070. On August 31, 2022, the immediacy for the correction order 2070 was removed, however, non-compliance remained at level 3/widespread scope.	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 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 SUBDIVISION 1-3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
0 480	Continued From page 1	0 480		
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 had the potential to affect all 18 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 or has the potential to affect a large portion or all the residents). The findings include:	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
0 480	Continued From page 2 Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 29, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents 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 August 30, 2022, between 10:10 a.m. and 11:10 a.m., survey staff toured the facility with	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
0 800	Continued From page 3 maintenance (M)-D. During the facility tour, survey staff observed the following: In the East/West building: 1. The window was open and the crank mechanism broken in the common-use bathroom. The exterior pane of this window was cracked. The M-D confirmed during an interview, at approximately 11:25 a.m., that this window required repair. At approximately 11:30 a.m., the M-D was able to close the window but the crank mechanism was still broken. TIME PERIOD FOR CORRECTION: Two (2) days In the East/West building: 2. Two marked emergency exits lead to an outdoor activity space for residents. This space was surrounded by a fence with a gate door that was secured with a lock that required a key to open. In the North/South building: 3. One electrical outlet was missing a cover in the kitchen. 4. The exhaust fan was not working in the common-use bathroom, this room was noted as being very humid. 5. The vanity base was chipped in several areas in the common-use bathroom, making this area difficult to maintain clean. On August 30, 2022, at approximately 12:30 p.m., during the exit interview with the LALD-A and M-D, the above items were confirmed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
0 810 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 observation, document review, and interview, the licensee failed to provide the	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
0 810	Continued From page 5 required plans 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 August 30, 2022, between 10:10 a.m. and 11:10 a.m., survey staff toured the facility with maintenance (M)-D. During the facility tour, survey staff observed that the number of resident sleeping rooms were not identified on the evacuation maps posted in the facility. On August 30, 2022, at approximately 11:15 a.m., the licensed assisted living director (LALD)-A provided documents for review. Documents were reviewed by survey staff on August 30, 2022, between 11:15 a.m. and 12:20 p.m. 1. The plans in the Chestnut Emergency Plans binder did not identify the number of resident sleeping rooms. 2. The 9.06 Fire Policy failed to include plans and procedures that were developed for the facility location. 3. The 9.06 Fire Policy failed to include the identification of unique or unusual resident needs for movement or evacuation. On August 30, 2022, at approximately 12:30 p.m., the LALD-A confirmed during the exit interview that the evacuation maps and plans required revision.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
0 810	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living agreement did not include language waiving the facility's liability for health, safety or personal property of a resident. 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 potential to affect a large portion or all of the residents). The findings include: R1 and R2's Assisted Living Contract dated July 29, 2022, and August 1, 2022, respectively,	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
0 970	Continued From page 7 contained a clause indicating the resident would waive the facility's liability as follows: "Liability: Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment Unit or on Provider's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. Provider is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third party providers. Provider may be liable to Resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons. Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on Provider's premises." Page 16, first paragraph. On August 31, 2022, at approximately 10:06 a.m., clinical nurse supervisor (CNS)-B and licensed assisted living director (LALD)-A confirmed the same assisted living service agreement contract was used for all residents at the facility. No further information available. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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 8 (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 a written service plan was revised to reflect the current services provided for one of three residents (R1) 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).	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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 9 The findings include: R1's service plan lacked revision to reflect the current services R1 was receiving. R1's Service Plan lacked the inclusion of supplemental oxygen, however, did include TEDs which had been discontinued. R1 was admitted for services on March 15, 2020. R1's diagnoses included dementia, anxiety and depression. R1's Service Plan dated July 23, 2021, indicated R1 required assistance with bathing, dressing, mobility assistance, grooming, incontinence care, medication administration, behavior management, denture care, safety checks, housekeeping, laundry and compression stockings (TEDs). On August 30, 2022, at approximately 7:33 a.m., the surveyor observed R1 sitting in a chair at the dining room table and R1 was wearing a nasal cannula attached to a portable oxygen tank. R1's oxygen delivery rate was set at 1 liter per minute (lpm). R1's prescriber orders, dated January 31, 2022, indicated R1 required assistance with supplemental oxygen 1 lpm via nasal cannula continuous. R1's 90-day reassessment dated August 1, 2022, included R1's activity of daily living, bio-history, dietary preference, independent living, medications, physical, safety and social and cognitive categories. Under the Respiratory Function section, clinical nurse supervisor	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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 10 (CNS)-B indicated R1 used oxygen supplement at 2 lpm. R1's Service Plan dated July 23, 2021, indicated R1 was to have TEDs applied every morning and removed every night, however, on April 6, 2022, R1's medical prescriber had discontinued the order for TEDs. On August 30, 2022, at approximately 8:59 a.m., CNS-B stated R1's reassessment/service plan should have been updated when she conducted R1's 90-day reassessment on August 1, 2022, so that the current services would be reflected on the service plan. The licensee's 6.08 Service Plans policy dated August 1, 2022, indicated all residents receiving assisted living services would have a service plan in place based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01710 SS=E	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.	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
01710	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for two of three residents (R1, 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on August 29, 2022, at 10:40 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the residents at the facility. R1 R1's diagnoses included dementia, anxiety and depression. R1's service plan dated July 23, 2021, indicated R1 received services which included medication administration. R1's prescriber orders dated January 31, 2022, included a blood thinner, a cholesterol reducer, an antipsychotic, antihypertensive, bladder infection preventative, mood stabilizer and an	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
01710	Continued From page 12 anticonstipation medication. R1's medication assessment dated August 1, 2022, indicated R1 was able to take oral medications whole, one at a time with a drink of water. On August 30, 2022, at 7:33 a.m., the surveyor observed housing manager (HM)-C who was working the floor the morning of August 30, 2022, administer R1's scheduled morning medications. HM-C verified the medications, crushed each medication and added the medications to a four ounce container of yogurt. HM-C spoon fed R1 the medicated yogurt. HM-C stated, "she likes to do it herself [R1], but we help her with the last few bites". R3 R3's diagnoses included dementia, stroke and hypertension. R3's service plan dated February 10, 2022, indicated R3 received services which included medication administration. R3's prescriber orders dated May 31, 2022, included a heart rate stabilizer, a blood thinner, one diuretic, one vascular enhancer, one thyroid medication, one antihypertensive, one vitamin supplement, one anticonstipation medication and a skin cream. R3's medication assessment dated June 13, 2022, indicated R3 took a narcotic pain reliever. On August 30, 2022, at 7:57 a.m., the surveyor observed HM-C administer R3's scheduled morning medications. The surveyor inquired about R3's narcotic pain medication and HM-C	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
01710	Continued From page 13 stated, "he hasn't taken that in months". R1 and R3's records lacked evidence the RN conducted a review of all medications the resident was known to be taking to include a review of the side effects and contraindications. On August 30, 2022, at approximately 9:33 a.m., clinical nurse supervisor (CNS)-B stated, "I must have missed those". Additionally, CNS-B stated R3's narcotic pain medication had been discontinued "during March 2022". The licensee's 7.03 Medications and Treatments policy dated July 12, 2021, indicated medication reconciliation would be completed when a licensed nurse, licensed health professional, or authorized prescriber was providing medication management. Additionally, the policy indicated the medication management record would be current and updated when there were any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
01880	Continued From page 14	01880		

review, the licensee failed to ensure prescription medications were stored according to the manufacturer's directions and failed to ensure prescription medications were stored in a secured manner allowing only authorized personnel 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On August 29, 2022, at approximately 12:11 p.m., in the presence of clinical nurse supervisor (CNS)-B, the surveyor observed a medication refrigerator located in a supply storage room used by all employees. The medication refrigerator lacked a lock to secure medications. The surveyor requested to review the medication refrigerator temperature log and it was provided by CNS-B.

The medication refrigerator contained medications belonging to R3 as follows:
- Shingrix zoster vaccine 50 micrograms (MCG)/0.5 milliliters (ml); and
- Adacel 5-2-15.5 LF-MCG/0.5 injection.

The manufacturer's instructions and Centers for Disease Control (CDC) guidelines for refrigerated vaccines dated February 2018, indicated vaccines should be stored in the refrigerator at 40 degrees Fahrenheit (F) and be discarded if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
01880	Continued From page 15 frozen. The refrigerator temperature log contained several readings at or below 32 degrees F on the following days in August 2022: - August 25, 26, 27, 28 and 29, 2022. On August 29, 2022, at approximately 12:11 p.m., CNS-B confirmed the refrigerator contained unsecured medications and the temperature log contained several readings at or below 32 degrees F. The surveyor asked CNS-B if she was aware of the safe range for vaccine storage in the refrigerator and CNS-B stated, "I'm not 100% sure, but I'll look at that and get ahold of the maintenance man". Additionally, CNS-B verified the vaccines were delivered to the facility on August 26, 2022. The licensee's 7.11 Medication Storage policy dated July 12, 2021, indicated all prescription drugs would be securely locked and stored according to the manufacturer's directions to include refrigerated, room temperature or frozen, and only authorized staff would have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
02040	Continued From page 16	02040		

property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and
(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.

This MN Requirement is not met as evidenced by:
Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. 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 August 30, 2022, at approximately 11:15 a.m., the licensed assisted living director (LALD)-A provided documents for review. Documents were reviewed by survey staff on August 30, 2022, between 11:15 a.m. and 12:20 p.m. The Hazard Vulnerability Assessment identified natural, technological, and human hazards but did not include hazards or safety risks identified on and around the property. The mitigation plan listed some of the hazards but the mitigation and comments sections were blank.

On August 30, 2022, at approximately 12:30 p.m., the LALD-A confirmed during the exit interview that the assessment did not include safety risks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
02040	Continued From page 17 or hazards identified on and around the property. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in the secured dementia care unit. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	02070	On August 31, 2022, the immediacy for the correction order 2070 was removed, however, non-compliance remained at level 3/widespread scope.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
02070	Continued From page 18 The findings include: The licensee held an Assisted Living with Dementia Care license with a bed capacity for 20 residents and had a current census of 18 residents. During the survey entrance conference on August 29, 2022, at approximately 10:50 a.m., the surveyor asked how the residents summoned staff when needed. Clinical nurse supervisor (CNS)-B and licensed assisted living director (LALD)-A stated all memory care staff "check on residents" and residents were in the common areas of the units during awake times so they could be observed by staff. LALD-A confirmed the facility did not have a call system in place for residents to request assistance when needed. On August 30, 2022, at approximately 10:30 a.m., the surveyor observed unlicensed personnel (ULP)-E rolling tobacco cigarettes in the nursing storage/medication room, located within the North/South unit. The surveyor inquired to ULP-E for information on how many residents in the North/South unit were smokers and if the smokers needed to have a staff member present while they smoked. ULP-E stated, "yes, seven of the residents smoke outside in the courtyard supervised. We have a schedule." The surveyor asked how many staff remained in the unit when seven of the eight residents were taken outside to smoke. ULP-E stated, "nobody, the only resident that doesn't smoke prefers to stay in her room to herself." On August 30, 2022, at approximately 10:44 a.m., the surveyor requested a copy of the smoking schedule from ULP-E to review. A document titled Supervised Smoking Schedule was provided to	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
02070	Continued From page 19	02070		

the surveyor. The document indicated residents that smoked and resided in the North/South unit were taken outside with a staff member every 90 minutes daily, starting at 8:30 a.m., and ending at 10:00 p.m.

The surveyor observed the physical layout of the facility consisted of two secured units separated by a secured main entry. Each of the three areas were accessed by coded keypads. The North/South unit served eight residents, seven smokers and one non-smoker. The East/West unit served ten residents, one smoker and nine non-smokers.

On August 30, 2022, at approximately 11:30 a.m., the surveyor observed ULP-E escort seven residents out to the courtyard from the North/South unit and assist them with lighting their [the residents] cigarettes. During this time, the surveyor observed CNS-B enter the North/South unit.

On August 30, 2022, at approximately 11:50 a.m., ULP-E stated he had worked the previous night shift from 11:00 p.m., to 7:00 a.m., and was working a double shift into the current day's morning shift. ULP-E verified the licensee regularly staffed one ULP per unit at night. ULP-E stated earlier in the day, at 8:00 a.m., and 10:00 a.m., he had taken the seven residents that smoked from North/East unit out to the courtyard and left one resident, (R4) unattended on the unit.

During an interview on August 30, 2022, at approximately 11:40 a.m., clinical nurse supervisor (CNS)-B verified the staffing schedule and stated two ULP's were scheduled for each shift and it "was only the late afternoons and weekends that were not covered by three staff"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
02070	Continued From page 20 members of the licensee. CNS-B stated, "it has been difficult to find staff" and management were able to fill in during the week, during the day. On August 30, 2022, at approximately 2:10 p.m., CNS-B confirmed the licensee's Resident Handbook dated July 2021, had been provided to residents upon admission and indicated residents had the ability to access designated outdoor smoking areas 24-hours a day, 7 days a week. The surveyor inquired about after hours and leaving residents unattended during the night shift, CNS-B stated, "it would be no different honestly after hours, if they [the residents] are in their rooms asleep, for the staff to go out with a resident for five minutes." The licensee's Smoking/Vaping policy, undated, did not address supervised smoking schedules or leaving residents unattended when staff are required or requested to be present outside with a smoking resident. The licensee's policy, Staffing and Scheduling, dated July 9, 2021, indicated qualified employees would be scheduled to meet the operational requirements and the needs of the residents. The policy indicated the CNS would ensure that staffing levels were adequate to address each residents needs 24-hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02070		
02370 SS=E	144G.91 Subd. 9 Right to come and go freely Residents have the right to enter and leave the	02370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
02370	Continued From page 21 facility as they choose. This right may be restricted only as allowed by other law and consistent with a resident's service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of seven residents (R6, R7) had the right to enter and leave the facility as they chose. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee held an Assisted Living with Dementia license. Two entrance/exits from the facility were secured with key-pad coded locking doors. R6 R6 was admitted on March 23, 2020, with a diagnosis of traumatic brain injury (TBI). R6's service plan dated February 10, 2022, indicated R6 received services to include activity assistance, bathing, dressing, escort and mobility assistance, grooming, behavior management, housekeeping, laundry and medication administration.	02370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
02370	Continued From page 22 R7 R7 was admitted on March 22, 2020, with a diagnosis of schizophrenia. R7's service plan dated February 10, 2022, indicated R7 received services to include activity assistance, bathing reminders, behavior management, grooming, housekeeping, meal assistance and reminders, laundry and medication administration. On August 31, 2022, at approximately 8:00 a.m., clinical nurse supervisor (CNS)-B and licensed assisted living director (LALD)-A confirmed R6 and R7 did not have a dementia diagnosis and CNS-B stated, "if given the code, they wouldn't remember it". LALD-A stated prior to assisted living regulation changes, licensee had a Board and Lodge with Special Services license. The surveyor asked if there was a concern with R6 or R7 having the key-code to come and go freely from the locked facility, CNS-B stated, "both of them" [R6 and R7] were a risk to themselves and the community if allowed to leave the facility on their own, "we have documentation of their [R6 and R7] behaviors". CNS-B stated the nurse practitioner would be ordering and conducting cognitive screening tests for R6 and R7, "it's been a while since those were done". The licensee's 2.30 Protecting Resident Rights policy dated August 1, 2022, indicated it was the policy of the licensee to protect the rights of residents and would not request or require that any resident waive any rights provided at any time for any reason, including as a condition of admission. No further information provided.	02370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(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
02370	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02370		

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

Type: Full
Date: *08/29/22*
Time: 10:45:00
Report: 7983221143

Food and Beverage Establishment Inspection Report

Location:
Chestnut Grove - Chestnut Grove - East
1204 West Chestnut Street
Virginia, MN55792
St. Louis County, 69

Establishment Info:
ID #: 0037487
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2187496846
ID #:

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

The following orders were issued during this inspection.

3-500A Microbial Control: cooling

3-501.13ABC

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

OBSERVED GREEN BEANS THAWING AT ROOM TEMPERATURE ON THE COUNTERTOP. THEY WERE PLACED INTO THE REFRIGERATOR.

Corrected on Site

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

THE FRIGIDAIRE WAREWASHING MACHINE, MODEL FFCD2413US2A, WAS NOT LABELED TO INDICATE COMPLIANCE WITH NSF/ANSI STANDARD 184 FOR RESIDENTIAL WAREWASHING MACHINES. REPLACE THE MACHINE OR PROVIDE EVIDENCE THAT IT MEETS THE STANDARD.

Comply By: 08/30/22

4-600 Cleaning Equipment and Utensils

4-602.12

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

THE INTERIOR OF THE MICROWAVE OVEN WAS DIRTY WITH FOOD DEBRIS.

Comply By: 08/29/22

4-900 Protecting Clean Items

4-904.11A

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

PLASTIC SPOONS STORED IN A CONTAINER IN A DRAWER WERE ARRANGED SUCH THAT THEIR HANDLES WERE POINTING IN DIFFERENT DIRECTIONS.

Comply By: 08/29/22

Food and Equipment Temperatures

Process/Item: Refrigerator/Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the freezer compartment of the Frigidaire refrigerator/freezer was frozen solid.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: 39 Degrees Fahrenheit - Location: Dressing (stuffing) in the refrigerator compartment of the Frigidaire refrigerator/freezer.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the freezer compartment of the Samsung refrigerator/freezer was frozen solid.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: 39 Degrees Fahrenheit - Location: Liquid egg product in the refrigerator compartment of the Samsung refrigerator/freezer.
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	4

==========

GENERAL COMMENTS:

1) Breakfast is prepared on-site. Lunch and supper items are prepared off-site at Hillcrest Adams and are delivered frozen.

==========

Type: Full
Date: *08/29/22*
Time: 10:45:00
Report: 7983221143
Chestnut Grove - Chestnut Grove - East

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7983221143 of 08/29/22.

Certified Food Protection Manager: Rachael Haupt

Certification Number: FM54036 Expires: 06/05/25

Inspection report reviewed with person in charge and emailed.

Signed: _____ Signed: 7983

Tricia Merrill
Person in Charge

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