Electronically Delivered

October 22, 2024

Licensee
Traditions Of Owatonna
195 24th Place Northwest
Owatonna, MN 55060

RE: Project Number(s) SL30519015

Dear Licensee:

On October 11, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 17, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

Electronically Delivered

August 15, 2024

Licensee
Traditions Of Owatonna
195 24th Place Northwest
Owatonna, MN 55060

RE: Project Number(s) SL30519015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 17, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

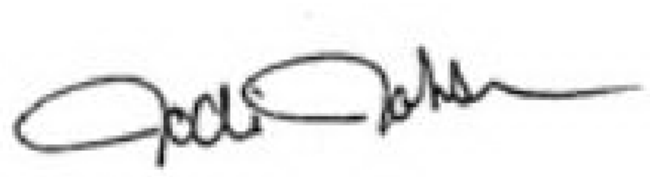
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30519	A. BUILDING: _____ B. WING _____	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF OWATONNA	195 24TH PLACE NW OWATONNA, MN 55060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30519015 On July 15, 2024, through, July 17, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 43 residents; 37 receiving services under the provider's Assisted Living Facility license. 2310: An immediate order was issued on July 17, 2024, at a level 3/Isolated (G). The immediacy was removed July 18, 2024, scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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

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0 470	Continued From page 2 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's census was 43 residents, 37 of whom received services under the assisted living license. During the entrance conference on July 15, 2024, at 11:07 a.m., licensed assisted living director (LALD)-A, assistant director (AD)-B, and clinical nurse supervisor (CNS)-C stated there were three unlicensed personnel (ULP) scheduled for 6:00 a.m. to 2:00 p.m. and one ULP scheduled 7:00 a.m. to 3:00 p.m. (on most days), two ULP scheduled from 2:00 p.m. to 10:00 p.m. and one-two ULP scheduled from 3:00 p.m. to 9:00 p.m., and two ULP from 10:00 p.m. to 6:00 a.m. STAFF POSTING During a tour of the facility on July 15, 2024, at 11:00 a.m., the surveyor observed an electronic monitoring sign at the front entrance, the facility license, grievance procedure information, contact information for the Ombudsman, Minnesota Adult Abuse Reporting Center information and reporting number, disaster plan and emergency exit diagrams; however, no posting of the daily staff schedule was observed during the tour. The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts,	0 470		

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0 470	Continued From page 3 including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On July 15, 2024, at 12:05 p.m., AD-B and LALD-A stated the schedule was posted behind the receptionist desk at the front entrance and was not accessible to clients or visitors. In addition, it did not show the date, all work shifts, or identify the direct-care staff members resident assignments or work location. AD-B and LALD-A stated they were not aware the staffing schedule needed to be accessible to residents or visitors. STAFFING PLAN The licensee's Direct Care Staffing Plan indicated the following review dates: - August 1, 2021 - April 1, 2022 - March 11, 2024 On July 17, 2024, at 1:45 p.m. AD-B reviewed the licensee's Direct Care Staffing Plan and stated it had not been reviewed twice yearly as required. The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule policy dated reviewed June 6, 2023, included: 5. The staffing plan will be evaluated for appropriate staffing levels in the facility and revised as needed at a minimum of two times per year. 7. The 24-hour daily staffing schedule will include: a. Direct-care staff work schedules for each direct-care staff member;	0 470		

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0 470	Continued From page 4 b. Indication of all work shifts, including days and hours worked; and c. Identify direct-care staff member's resident assignments or work locations. 8. The daily work schedule will be posted at the beginning of each shift. 10. The daily work schedule will be posted in a central location in each building of a facility or campus accessible to staff, residents, volunteers, and the public. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective October 2022, the clinical nurse supervisor (CNS) must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. The daily staffing schedule must be posted, after reacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 5 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 16, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is:	0 620		

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0 620	Continued From page 6 (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572,	0 620		

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0 620	Continued From page 7 subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for two of two residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 R4's diagnoses included Parkinson's disease and dementia with Lewy bodies. R4's Service Plan Detail signed April 1, 2024, indicated R4 required mechanical lift with assist of two staff members for transfers. On July 16, 2024, at 7:27 a.m. R4 stated having to tell staff to "slow down", and further stated,	0 620		

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0 620	Continued From page 8 they say they're always in a race to get done first. R4 stated when he first came to the facility, they (staff) tipped a Hoyer (lift) over with me in it; then I found out they were supposed to have two people running it and they only had one. R4 stated he obtained a large bruise on his back because of the fall and that his daughters set-up cameras in his room after the incident. R4 further stated, "That's when I found out I have some rights; they tried it a few more times with just one person and I spoke up and told them no". R4's incident report dated January 24, 2024, indicated: Resident was laying in his bed and staff was preparing him for a transfer. Resident was hooked up to the lift machine and laying in bed when staff went to turn to their right to grab something and once their foot left the machine footing, the machine tilted over to the left causing resident to fall approximately 2.5 (two feet, six inches) ft (feet) from the bed to floor. Lift machine foot jabbed resident in the left side of rib cage. Resident c/o (complained of) L (left) arm pain and unable to do full ROM (range of motion). Staff was able to assist resident with lift machine into his w/c (wheelchair). Staff observed the lift machine feet to be closed and not partially open to evenly distribute weight of resident causing the lift to tilt. Staff educated on importance of opening machine legs to distribute weight evenly. The incident report also indicated there was only one staff present assisting the resident with the transfer. R4 was transported to the hospital via emergency medical services (EMS) for further evaluation. On July 16, 2024, at 11:15 a.m. unlicensed personnel (ULP)-E and ULP-G stated R4 was always to be transferred with two staff.	0 620		

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0 620	Continued From page 9 On July 17, 2024, at 9:42 a.m. licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C stated the expectation for any resident utilizing a Hoyer lift was that two staff were to always be performing the transfer. LALD-A could not find evidence a MAARC report had been submitted for R4's above fall. R5 R5's diagnoses included chronic obstructive pulmonary disease (COPD) and type two diabetes. R5's Service Plan last modified May 16, 2024, indicated R5 was susceptible to abuse by another individual, including other vulnerable adults. R6's Record of Grievance/Compliant form dated July 8, 2024, indicated the resident stated she was missing $200 from her dresser drawer. Though the complaint was investigated and found to be unsubstantiated, there was no evidence the financial exploitation allegation had been reported to MAARC. On July 17, 2024, at 11:52 a.m. assistant director (AD)-B stated she followed up with R5's son who thought his mother had spent the money and forgot about it. AD-B stated she had reviewed the complaint with licensed assistant living director (LALD)-A and was not directed to report the complaint to MAARC. On July 17, 2024, at 12:22 p.m. LALD-A stated she did not report R5's allegation of missing money to MAARC. LALD-A stated R5's son was interviewed and felt R5 had probably spent the money and forgot about it as she had been out shopping. R5's son further had stated R5 received the money several months ago. LALD-A	0 620		

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0 620	Continued From page 10 stated not being aware of the missing money allegation until Monday morning (July 8, 2024) as R5 had reported this to staff over the weekend prior. The licensee's Vulnerable Adult Maltreatment Policy dated June 1, 2023, indicated: 4. Any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately to their supervisor, a nurse, or the Assisted Living Director and that person will complete an incident report. a. If the incident appears to be suspected abuse, neglect, or financial exploitation, the LALD or CNS will immediately make a report to the CEP (common entry point). "Immediately" means as soon as possible, but no longer than 24 hours from the time the LALD or CNS received initial knowledge that the incident occurred. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and	0 640		

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	30519	A. BUILDING: _____ B. WING _____	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 640	Continued From page 11 (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone number for 911 emergency number as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility. During a tour of the facility on July 15, 2024, at 11:00 a.m., the surveyor observed the entry and common areas within the facility and noted there was no posting of the 911 emergency number as required. On July 15, 2024, at 12:07 p.m. assistant director (AD)-B and licensed assisted living director (LALD)-A stated the 911 emergency number was not posted.	0 640		

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0 640	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of two employees (unlicensed personnel (ULP)-E and ULP-F).	0 650		

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0 650	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E ULP-E started employment on December 15, 2021. ULP-F ULP-F started employment on January 25, 2023. ULP-D and ULP-F's employee records lacked evidence of the following: - documentation of annual performance reviews that identify areas of improvement needed and training needs. On July 17, 2024, at 1:45 p.m. assistant director (AD)-B stated there was no evidence of annual performance reviews for ULP-E or ULP-F. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated as reviewed June 1, 2023, noted performance reviews would be conducted annually at a minimum. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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0 660	Continued From page 14	0 660		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screen for two of two employees (unlicensed personnel (ULP)-E, ULP-F) and completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test, for two of two employees (ULP-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 660		

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0 660	Continued From page 15 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB facility risk assessment dated August 2, 2023, indicated the licensee was a low risk. ULP-E ULP-E was hired December 15, 2021, to provide direct care services. On July 16, 2024, at 9:59 a.m. ULP-E was observed applying sequential compression device (SCD) leg pumps (inflatable sleeves that fit around your legs) to R4's lower legs. ULP-E's employee record included a TB symptom screen from a former employer dated March 22, 2021. The record further included 2-step TST testing from the same prior employer. The first step placed March 22, 2021, and read March 24, 2021; the second step placed March 29, 2021, and read March 31, 2021. The TB symptom screen and two-step TST testing was completed greater than eight months prior to hire. ULP-F ULP-F was hired January 25, 2023, to provide direct care services. ULP-F's employee record lacked documentation of a TB symptom screen and two-step TST or other evidence of TB screening. On July 16, 2024, at 12:55 p.m. licensed assisted	0 660		

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0 660	Continued From page 16 living director (LALD)-A stated ULP-F's employee file lacked the above TB requirements. LALD-A reviewed ULP-E's TB symptom screen and TB testing from a previous employer upon hire and stated it did not meet the requirements. The licensee's TB Prevention and Control policy reviewed December 9, 2022, indicated: 3. Staff Screening & Testing: staff refers to all paid employees, unpaid employees, contractors, students, and regularly scheduled volunteers. a. Upon hire staff will be screened for TB symptoms and tested for TB. Staff will not work in resident care areas or areas where there is potential contact or shared space with residents until TB testing and screening is completed and a negative TB test is provided. i. If the first step of the two-step TST is negative the employee may begin working with residents (if the TST is dated within 90 days before hire) but must have the second TST test within 21 days after hire. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660		

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0 660	Continued From page 17 (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to practice and document testing of its emergency preparedness (EP) plan at least twice annually as required. This had the potential to affect all residents, staff, and visitors of the facility.	0 680		

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0 680	Continued From page 18 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: The EP plan included documentation of a facility-based functional elopement drill dated March 22, 2024. The documentation included staff member names and analyzed the facility's response to the event. However, the EP plan lacked evidence the facility had tested its EP plan, conducted and/or participated in a full-scale community-based exercise, or conducted a tabletop exercise to test its plan and document the results of testing at least twice annually as required. On July 17, 2024, at 3:00 p.m. assistant director (AD)-B stated the licensee's EP plan lacked the above required components. The licensee's Emergency Preparedness Training policy dated revised August 1, 2021, noted facilities are required to conduct a tabletop exercise and participate in a full-scale community-based exercise or conduct an individual facility exercise if a community-based exercise is not available. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for	0 680		

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0 680	Continued From page 19 long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 690 SS=E	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in the resident's records were authenticated by the title of the person making the entry for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	0 690		

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0 690	Continued From page 20 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's comprehensive assessments dated December 26, 2023, was not authenticated with the title of the person completing the assessment. R3 R3's comprehensive admission assessment dated May 7, 2024, was not authenticated with the title of the person completing the assessment. R4 R4's comprehensive assessments dated December 21, 2023, and March 18, 2024, were not authenticated with the title of the person completing the assessment. On July 17, 2024, at 9:27 a.m. clinical nurse supervisor (CNS)-C reviewed R4's comprehensive assessments and stated they had not been authenticated by the nurse completing the assessment. On July 17, 2024, at 12:34 p.m. CNS-C reviewed R2 and R3's comprehensive assessments and stated they had not been authenticated by the title of the individual completing the assessment. CNS-C stated she was not aware the title was not populating when it was signed in their computer system and indicated they had switched software programs a few months prior. The licensee's Resident Records policy dated as reviewed June 6, 2023, included: 1. Record entries will be legible, permanently recorded, dated, and signed by the person	0 690		

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0 690	Continued From page 21 making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the	0 730		

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0 730	Continued From page 22 resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on September 13, 2022, and discharged to another facility on May 28, 2024. R1's record lacked a discharge summary.	0 730		

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0 730	Continued From page 23 On July 15, 2024, at 12:47 p.m. clinical nurse supervisor (CNS)-C stated R1's record lacked a discharge summary. CNS-C further stated a discharge summary should have been completed when R1 discharged to another facility. The licensee's Resident Records policy dated as reviewed June 6, 2023, indicated the resident record would contain: n. Discharge summary, including service termination notice and related documentation when applicable. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so	0 780		

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0 780	Continued From page 24 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Tag 0780 Based on observation and interview, the licensee failed to provide smoke alarms inside the resident rooms in compliance with Minnesota Fire Code. This deficient condition had the ability to affect all staff and 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 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: During the facility tour on July 16, 2024, with the director of maintenance (DM), between 12:00 p.m. and 3:30 p.m., it was observed that the smoke alarms inside the resident rooms were over 10 years old from date of manufacture. The DM removed a smoke alarm, and the date was verified. The DM will check all resident rooms smoke alarms for manufacture date and replace if required.	0 780		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF OWATONNA	195 24TH PLACE NW OWATONNA, MN 55060

(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
0 780	Continued From page 25 Surveyor explained to the DM, that all smoke alarms shall comply with the Minnesota State Fire Code which states all smoke alarms over 10 years old from date of manufacture shall be replaced. The deficient conditions were visually verified by the DM accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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 maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 800		

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0 800	Continued From page 26 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: During the facility tour on July 16, 2024, with the director of maintenance (DM), between 12:00 p.m. and 3:30 p.m. the following facility hazards and disrepair were observed: FIRE DOORS: Surveyor observed several fire doors that were propped open, had the pins removed from hinges or had a various devices holding them open. The DM stated he had taken the pins out of the hinges. All doors to the corridors or stairwells shall close and latch under their own power. Several resident room doors were propped open. Surveyor explained to the DM, that all doors to the corridor must meet the state statute for fire doors and the fire rating shall be always maintained. EMERGENCY/ EXIT LIGHTS: Surveyor observed the exit/emergency lights failed to operate when push button tested by the DM. Surveyor explained to the DM that all emergency/exit lights shall operate when push button tested, be push button tested monthly, the 30-minute test completed annually and shall comply with the Minnesota State Fire Code. LOCKS:	0 800		

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0 800	Continued From page 27 Surveyor observed a hasp lock with a paddle lock on the cooler door. Surveyor explained to the DM that the cooler door shall be openable from inside the cooler at all times. FIRE SPRINKLER HEADS: Surveyor observed a fire sprinkler head blocked by storage in the kitchen storage room. Surveyor explained to the DM that fire sprinkler heads shall not be blocked so they can be effective in case of fire. Storage shall be a minimum of 18 inches below the fire sprinkler deflector. The deficient conditions were visually verified by the DM accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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	0 810		

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0 810	Continued From page 28 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, interview and record review, the licensee failed to provide required training and drills for employees and residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).	0 810		

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0 810	Continued From page 29 The findings include: TRAINING: During record review, a copy of resident training records and the training policy were requested but were not able to be provided. During interview the DM stated they had no further documentation to provide. During record review, a copy of employee training records and the training policy were requested but were not able to be provided. During interview DM stated they had no further documentation to provide. EVACUATION DRILLS: During interview a copy of evacuation drill documentation and policy were requested. DM provided some drill documentation, but it lacked the required signatures and were not performed as required. Surveyor explained to the DM, the evacuation drills shall be completed and documented with employee signatures. The deficient conditions were verified by the DM after the above review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as	0 820		

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0 820	Continued From page 30 housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on July 16, 2024, with the director of maintenance (DM), between 12:00 p.m. and 3:30 p.m. the following facility hazards and disrepair were observed: EXIT DOORS:	0 820		

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0 820	Continued From page 31 Surveyor observed the southeast exit door had an exit sign posted on it and this door was designated as an emergency exit on the posted evacuation map. There was a magnetic lock on the interior side of this door that required entry of a code into a keypad beside the door to exit. This area was used for dementia care residents in the past but is not presently. The surveyor explained to the DM that all exit doors shall open from the inside with one motion and no special knowledge and shall comply with the Minnesota State Fire Code. The deficient conditions were visually verified by the DM accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in	01620		

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01620	Continued From page 32 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 resident assessment within 14 days of admission for three of three residents (R2, R3, R4) and ongoing resident reassessments that did not exceed 90 days for two of two residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R2 R2 was admitted and began receiving assisted living services on September 11, 2023. R2's service plan dated September 12, 2023, identified R2 received assistance with an ankle foot orthosis (AFO) brace (provides gait stability,	01620		

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01620	Continued From page 33 keeps joints aligned, and helps compensate for muscle weakness) to left foot, dressing, grooming, toileting, blood sugar checks, medication management services, laundry, and light housekeeping. R2's record included an admission assessment dated September 11, 2023, and a 14-day assessment dated September 26, 2023. The 14-day assessment was 15 days after the date of the admission assessment, exceeding the 14 calendar days. In addition, R2's record included an assessment dated December 26, 2023. The December 26, 2023, assessment was 92 days from the last date of the assessment on September 26, 2023, exceeding 90 calendar days. R2's record lacked evidence of additional comprehensive nursing assessments after the December 26, 2023, assessment had been completed. R3 R3 was admitted and began receiving assisted living services on May 7, 2024. R3's Service Plan dated May 7, 2024, indicated services included bathing assistance, blood glucose checks, and medication administration. R3's record included an admission assessment dated May 7, 2024. R3's record lacked evidence of a 14-day assessment after the May 7, 2024, assessment had been completed. R4 R4 was admitted and began receiving assisted living service on December 21, 2023. R4's service plan signed April 1, 2024, identified	01620		

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01620	Continued From page 34 R4 received medication management services, assistance with compression stockings, all activities of daily living, activities, laundry, and light housekeeping. All R4's assessments were requested. R4's record indicated the RN completed assessments on December 21, 2023, and March 18, 2024. R4's record lacked a 14-day assessment and a current 90-day assessment that was due on June 16, 2024. R4's record indicated the RN completed a reassessment on May 15, 2023, and on August 21, 2023, (98 days passed between assessments, or eight days late). On July 16, 2024, at 12:31 p.m. clinical nurse supervisor (CNS)-C stated R2 and R3's above named assessments were late and stated R2 did not have an assessment schedule set up with the change over to the new software. On July 17, 2024, at 9:27 a.m. CNS-C stated R4's record lacked evidence a 14-day assessment or a current 90-day assessment had been completed. The licensee's Initial and On-going Nursing Assessment of Residents Under the Licensed Agency policy dated as reviewed June 6, 2023, noted a RN would complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Pre-admission assessment; b. 14-day assessment: completed up to 14-days after start of services; c. Ongoing assessment: completed periodically but no less than every 90 days;	01620		

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01620	Continued From page 35 d. Change in resident conditions. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of three residents (R4).	01640		

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01640	Continued From page 36 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 16, 2024, at 7:27 a.m. R4 stated staff applied leg pumps to his lower legs for one hour twice a day. On July 16, 2024, at 9:59 a.m. unlicensed personnel (ULP)-E was observed applying sequential compression device (SCD) leg pumps (inflatable sleeves that fit around your legs) to R4's lower legs. ULP-E stated R4 had been utilizing the leg pumps for approximately two weeks. R4's service plan signed April 1, 2024, identified R4 received medication management services, assistance with compression stockings, all activities of daily living, activities, laundry, and light housekeeping. The service plan failed to identify the treatment of SCD leg pumps. On July 17, 2024, at 9:27 a.m. clinical nurse supervisor (CNS)-C stated R4's SCD leg pumps had not been added to the service plan; although staff were documenting when the treatment was completed. The licensee's Contents of Service Plans policy reviewed June 6, 2023, indicated:	01640		

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01640	Continued From page 37 4. Service plans are reviewed and revised as needed based upon on-going resident assessment. 5. Service plans will include: a. A description of the services provided. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed by one of one unlicensed personnel (ULP-E) observed during medication administration. 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	01750		

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01750	Continued From page 38 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's Service Plan dated May 7, 2024, indicated services included bathing assistance, blood glucose checks, and medication administration. R3's prescriber orders April 28, 2024, included insulin lispro (fast-acting insulin) pen-injector 100 units/milliliter (ml), inject six units under the skin with breakfast, lunch, and evening meal. On July 16, 2024, at 8:05 a.m. ULP-E stated R3 had a scheduled insulin lispro injection and showed the surveyor the order on R3's electronic medication administration record (eMAR). ULP-E obtained R3's insulin lispro Kwikpen from the medication cart, removed the cap, used an alcohol pad to cleanse the rubber seal and then primed the pen by wasting two units of insulin. ULP-F then applied the new needle and dialed the pen to six units. ULP-E did not waste two units of insulin after the new needle was applied. ULP-E then proceeded to administer the insulin subcutaneously to R3's right lower abdomen. Immediately following the observation, ULP-E was asked about wasting two units of insulin prior to applying the needle; not after the needle was applied. ULP-E stated that is how she was taught and the process she always used. On July 16, 2024, at 12:36 p.m. clinical nurse supervisor (CNS)-C stated staff were trained to cleanse the end of the insulin pen with an alcohol pad, apply a new needle, do a two (2) unit waste,	01750		

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01750	Continued From page 39 then dial the prescribed insulin amount. Humalog KwikPen (insulin lispro pen) instructions for use dated revised July 2023, noted: Step 4: Push the capped needle straight onto the pen and twist the needle on until it is tight. Step 5: Pull off the outer needle shield. Do not throw it away. Pull off the inner needle shield and throw it away. Priming your pen: Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your pen, turn the dose knob to select 2 (two) units. Step 7: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and "0" is seen in the dose window. Hold the dose knob in and count to 5 (five)slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat priming steps 6 (six) to 8 (eight), no more than 4 (four) times. If you still do not see insulin, change the needle and repeat priming steps 6 (six) to 8 (eight). The licensee's undated, Insulin Pen Administration Competency instructed: - Remove the pen cap. Clean the rubber seal on the insulin cartridge with a sterile alcohol swab. - Attach the disposable needle to the pen by twisting needle onto pen hub securely. - Prime the pen before each injections: This releases a small amount of insulin into the pen to help get rid of air bubbles that may be in the pen.	01750		

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	30519	A. BUILDING: _____ B. WING _____	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF OWATONNA	195 24TH PLACE NW OWATONNA, MN 55060

(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
01750	Continued From page 40 Air bubbles can affect the flow of insulin and cause you to inject the incorrect amount. - Point the needle up. Gently tap the insulin cartridge to force any air bubbles to the top. - Dial 2 (two) units of insulin on the dose selector. For most insulin pens, you will hear a click for each unit of insulin that you have dialed. Point the needle up. Firmly press the plunger until a drop of insulin appears at the needle tip. If a droplet does not appear contact nursing for further instruction. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
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 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	01940		

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	30519	A. BUILDING: _____ B. WING _____	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF OWATONNA	195 24TH PLACE NW OWATONNA, MN 55060

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01940	Continued From page 41 problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized treatment management plan to include all required content for two of three residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 15, 2024, at 11:07 a.m., clinical nurse supervisor (CNS)-C stated the licensee provided treatment management services to the licensee's residents. R2 R2's diagnoses included hemiplegia (severe or complete one-sided loss of strength or paralysis)	01940		

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01940	Continued From page 42 and hemiparesis (slight weakness on one side of the body). R2's service plan dated September 12, 2023, identified R2 received assistance with an ankle foot orthosis (AFO) brace (provides gait stability, keeps joints aligned, and helps compensate for muscle weakness) to left foot, dressing, grooming, toileting, blood sugar checks, medication management services, laundry, and light housekeeping. R2 lacked prescriber orders for the AFO. On July 16, 2024, at 7:15 a.m. R2 was observed with an AFO brace on his left lower extremity. On July 16, 2024, at 12:04 p.m. unlicensed personnel (ULP)-F stated R2 wore an AFO brace to left foot every day and required assistance with application. ULP-F stated she had applied R2's AFO brace during his morning cares. R2's Treatment Assessment and Plan dated December 26, 2023, indicated R2 received assistance with brace applied/removed as ordered. R2's treatment plan did not include the following required content: - documentation of specific resident instructions relating to the treatments; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - 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.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 43 On July 17, 2024, at 11:37 a.m. clinical nurse supervisor (CNS)-C stated R2's treatment management service plan did not include the required content as listed above. R4 On July 16, 2024, at 7:27 a.m. R4 stated staff applied leg pumps to his lower legs for one hour twice a day. On July 16, 2024, at 9:59 a.m. ULP-E was observed applying sequential compression device (SCD) leg pumps (inflatable sleeves that fit around your legs) to R4's lower legs. ULP-E stated R4 had been utilizing the leg pumps for approximately two weeks. R4's Services Delivered dated July 1, 2024, thru July 15, 2024, indicated staff had documented on completion of applying/removing R4's SCD leg pumps twice daily since July 9, 2024. R4's service plan signed April 1, 2024, identified R4 received medication management services, assistance with compression stockings, all activities of daily living, activities, laundry, and light housekeeping. R4's service plan lacked a written statement of the treatment or therapy services that would be provided to the resident (SCD leg pumps) and lacked a current individualized treatment and therapy management record for the treatment service of SCD leg pumps for the following: -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 44 On July 17, 2024, at 9:27 a.m. CNS-C stated R4's Service Plan had not been updated when the leg pumps came in. CNS-C further stated R4's record did not include directions to staff for contacting a registered nurse when problems arose. The licensee's Individualized Medication, Treatment, and Therapy Management Plans policy dated as reviewed December 9, 2022, indicated the RN would develop a treatment and therapy management plan for each resident receiving treatment and/or therapy management services. The treatment and therapy management plan would include: b. Documentation of specific resident instructions relating to the treatments and/or therapy administration; d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments and/or therapy services; e. 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 and/or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The	01970		

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01970	Continued From page 45 order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for two of three residents (R2, R4) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 R2's diagnoses included hemiplegia (severe or complete one-sided loss of strength or paralysis) and hemiparesis (slight weakness on one side of the body). R2's service plan dated September 12, 2023, identified R2 received assistance with an ankle foot orthosis (AFO) brace (provides gait stability, keeps joints aligned, and helps compensate for muscle weakness) to left foot, dressing, grooming, toileting, blood sugar checks, medication management services, laundry, and	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01970	Continued From page 46 light housekeeping. On July 16, 2024, at 7:15 a.m. R2 was observed with an AFO brace on his left lower extremity. On July 16, 2024, at 12:04 p.m. unlicensed personnel (ULP)-F stated R2 wore an AFO brace to left foot every day and required assistance with application. ULP-F stated she had applied R2's AFO brace during his morning cares. R2's record lacked prescriber orders for the AFO brace. On July 17, 2024, at 11:37 a.m. clinical nurse supervisor (CNS)-C stated R2's record lacked prescriber orders for the AFO brace. CNS-C stated there should be prescriber orders for an AFO braced applied by staff daily. R4 On July 16, 2024, at 7:27 a.m. R4 stated staff applied leg pumps to his lower legs for one hour twice a day. On July 16, 2024, at 9:59 a.m. ULP-E was observed applying sequential compression device (SCD) leg pumps (inflatable sleeves that fit around your legs) to R4's lower legs. ULP-E stated R4 had been utilizing the leg pumps for approximately two weeks. R4's service plan signed April 1, 2024, identified R4 received medication management services, assistance with compression stockings, all activities of daily living, activities, laundry, and light housekeeping. R4's Services Delivered dated July 1, 2024, thru July 15, 2024, indicated staff had documentation	01970		

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01970	Continued From page 47 on applying/removing R1's SCD leg pumps twice daily since July 9, 2024. R4's medical record lacked evidence of a prescriber order for the SCD leg pumps. On July 17, 2024, at 9:27 a.m. CNS-C stated she had requested an order for R4's SCD leg pumps from his provider; although had not received one yet. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated as reviewed August 1, 2021, included the nurse would document actions to implement a new prescription when it is received, and actions to request and obtain needed refills for clients, including communications with the prescriber, pharmacy, client and/or client's representative or family. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and	02310		

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02310	Continued From page 48 services were provided according to acceptable health care, medical or nursing standards for one of two residents (R4) with a bed rail. This resulted in an immediate correction order on July 17, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 16, 2024, at 7:27 a.m. R4's room was observed to have a bed with bilateral Halo assist bars attached to the head of the bed. On July 16, 2024, at 11:15 a.m. unlicensed personnel (ULP)-E and ULP-G were observed transferring R4 into bed and changing his brief. R4 was observed to grab onto the assist bars when rolled from side to side during the brief change. R4's diagnoses included Parkinson's disease and Lewy Body dementia. R4's Service Plan Detail signed April 1, 2024, indicated R4 received services including medication administration, treatments, housekeeping, laundry, and assistance with bathing, dressing, grooming, transfers, and ambulation. R4's record lacked:	02310		

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02310	Continued From page 49 - an assessment for bed rail use; - documentation of risk vs. benefits discussion with R4 and responsible party; - documentation R4's bed rail was used, installed, and maintained per manufacturer's instructions; and - documentation R4's bed rail was checked for recalls with the Consumer Product Safety Commission (CPSC). On July 17, 2024, at 9:27 a.m. clinical nurse supervisor (CNS)-C reviewed R4's record and could not find evidence the above content had been completed. The Food and Drug Administration's (FDA) A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006, indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer	02310		

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02310	Continued From page 50 in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The MDH website also indicated for consumer bed rails, the licensee should refer to the CPSC for the most up-to-date information related to portable bed rail recall information. The licensee's Devices and Device Assessment policy reviewed June 6, 2023, indicated: 1. If the resident expresses the desire to use a device or a device is in use/recommended, a nurse will complete a device assessment at the time of move in, upon hospital return, change in condition, and/or upon discovery of a rail. 2. The licensed nurse or designee will review the risks and benefits of device use and potential device alternatives with the resident and/or responsible party. 3. Devices will be installed as appropriate for the type of bed: a. For hospital beds: Devices will be	02310		

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02310	Continued From page 51 installed per FDA guidelines. b. For non-hospital beds: Devices will be installed according to the device manufacturer's instructions. 4. Documentation will be entered in the resident's record to include: a. Results of the assessment. b. Discussion with resident/responsible party regarding risks and benefits and alternatives considered/recommended. c. Decision made/outcome of discussion. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On July 18, 2024, the immediacy of correction order 2310 was removed; however, non-compliance remains at a scope and level of G.	02310		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/16/24*
Time: 10:19:36
Report: 8044241164

Food and Beverage Establishment Inspection Report

Location:
Traditions Of Owatonna
195 24th Place Nw
Owatonna, MN55060
Steele County, 74

Establishment Info:
ID #: 0038679
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 5174135046
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

Milk in glass door cooler measured at 44 degrees F.

Milk moved to walk in cooler while on site.
Comply By: 07/16/24

4-500 Equipment Maintenance and Operation

4-501.114C1 ***** Priority 1 *****

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

Chlorine in dishwasher measured at 0 ppm.

Use three compartment sink to sanitize all dishes until new dishwasher is installed.
Comply By: 07/16/24

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

Mold in ice machine.

Food residues on can opener blade.

Comply By: 07/16/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

A state of Minnesota certified food protection manager certificate is required in addition to the course certificate.

Comply By: 09/16/24

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.

Glass door beverage cooler does not meet requirements.

Comply By: 08/16/24

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

Ice machine not cleaned frequently to prevent mold growth.

Comply By: 07/16/24

Surface and Equipment Sanitizers

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

Chlorine: = 0 ppm at Degrees Fahrenheit
Location: Dishwasher
Violation Issued: Yes

Food and Equipment Temperatures

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

Process/Item: Cold Holding
Temperature: 39.8 Degrees Fahrenheit - Location: Sliced turkey in WIC
Violation Issued: No

Process/Item: Cold Holding
Temperature: 44.1 Degrees Fahrenheit - Location: Milk in glass door cooler
Violation Issued: Yes

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

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

HRD inspection conducted with nurse evaluator Wendy Buckholz and Susan Kalis. Inspection report reviewed on site with Krystal Braund.

Establishment Info: krystalb@pscminn.com

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 8044241164 of 07/16/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Signed: _____
Inspector signed for Krystal

Signed: _____

Michael DeMars, RS
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