Electronically Delivered

October 7, 2022

Administrator
Laurels Edge Assisted Living
77 Stadium Road
Mankato, MN 56001

RE: Project Number(s) SL30675015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 15, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

Free from Maltreatment reconsideration requests should be addressed to:
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Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
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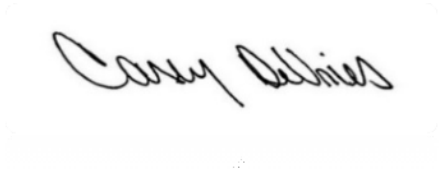
St. Paul, MN 55164-0970

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

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30675	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS EDGE ASSISTED LIVING	77 STADIUM ROAD MANKATO, MN 56001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30675015-0 On September 12, 2022, through September 15, 2022, the Minnesota Department of Health conducted a survey at the above provider and the following correction orders are issued. At the time of the survey, there were 37 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 14, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) 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: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a menu was prepared at least a week in advance and provided to the residents. This had the potential to affect all 37 residents at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than	0 485		

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0 485	Continued From page 3 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: During the entrance conference on September 12, 2022, at approximately 10:54 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated they provided residents three meals and snacks daily. On September 12, 2022, at approximately 11:58 a.m., surveyors toured the facility with licensed practical nurse (LPN)-B. The main dining room was on first floor and in the hallway, on a wall opposite the dining room, was a display titled "Menu" and which had three areas in which to display. The left area displayed breakfast time and foods offered; the middle display area was blank and the left side displayed the facility's "anytime" menu items. In the locked memory unit, there was no menu displayed, but on a table, there was a single-page flyer "The Edge Chronicle" which listed the current day's lunch and supper menu. On September 13, 2022, at approximately 8:50 a.m., surveyors observed, posted on the "menu" board, all meals for the day. However, the menu was only for the current day. On September 14, 2022, at approximately 11:03 a.m., LALD/RN-A verified the menu posted was not at least a week out, but only the current day's offering. LALD/RN-A said they had a 14-day, rolling food menu and added "it should be out	0 485		

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0 485	Continued From page 4 there." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required information about the licensee's grievance procedure, contact information for the Ombudsmen for Long-Term Care and Mental Health and Developmental Disabilities and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all 37 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	0 550		

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0 550	Continued From page 5 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 September 12, 2022, at approximately 11:58 a.m., the surveyors, with licensed practical nurse (LPN)-B, briefly toured the facility. The licensee's grievance procedure and complaint form were hanging on a wall in the main entry area. Neither document included the name, phone and email contact information of the person from the facility responsible to handle resident complaints; the policy directed "ULP (unlicensed personnel) and nursing staff of Monarch Healthcare Management" was the responsible staff to implement this policy. The phone number for reporting suspected maltreatment to MAARC was found next to a phone in the locked memory unit, but the contact number was not displayed in the main common area. On September 14, 2022, at approximately 11:04 a.m., licensed assisted living director/registered nurse (LALD/RN)-A talked about the required disclosures for reporting a complaint, the Ombudsmen and MARRC. LALD/RN-A was certain the information was posted in the facility and mentioned they had been cited for the same thing at another company facility. LALD/RN-A later verified the required disclosures and information was not posted and said "it was totally my fault" in not getting the word out and that they would correct this right away. No further information provided.	0 550		

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0 550	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure abuse prevention plans included all required assessments for three of three residents (R1, 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 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:	0 630		

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0 630	Continued From page 7 R1, R3, and R4's abuse prevention plans lacked assessment of the residents' susceptibility to abuse by another individual, including other vulnerable adults. R4 also lacked assessment of the resident's risk of abusing other vulnerable adults. R1 R1's diagnoses included type 2 diabetes, hyperlipidemia, chronic kidney disease, chronic respiratory failure, restless leg syndrome, esophageal reflux disease, hypertension, edema, anxiety disorder and dementia. On September 12, 2022, at approximately 2:03 p.m., the surveyor observed unlicensed personnel (ULP)-J administer medications to R1. R1's Vulnerability Assessment/Abuse Prevention Plan, dated May 10, 2022, assessed vulnerabilities, among which included, orientation to self, visual difficulties, pain, choric pulmonary hypertension and included assessment of R1's risk of abusing other vulnerable adults. Item no. 27 of the plan indicated R1 "has some identified areas of potential vulnerability, but there are no signs of abuse or neglect. Client [R1] does not appear to pose a threat to other vulnerable adults." On September 14, 2022, at approximately 10:50 a.m., licensed assisted living director/registered nurse (LALD/RN)-A said she felt R1's risk of being abused was assessed. LALD/RN-A stated if an area of vulnerability was not noted on the form, the sub-items on the form did not print out. Later at approximately 12:31 p.m., LALD/RN provided the surveyor with a blank vulnerability assessment form and referenced item no. 27 (noted above) which LALD/RN-A indicated	0 630		

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0 630	Continued From page 8 addressed this requirement. R3 R3's diagnoses included chronic pain syndrome, anxiety disorder, major depressive disorder, and COPD (chronic obstructive pulmonary disease.) On September 12, 2022, at approximately 2:49 p.m., the surveyor observed ULP-D administer medications to R3. R3's Vulnerability Assessment/Abuse Prevention Plan, dated November 30, 2021, identified the following vulnerabilities among which included pain, risk for falls, history of falls, frequent bruising, anxiety/depression, and included assessment of R3's risk of abusing other vulnerable adults. Item no. 27 of the plan indicated R3 "has some identified areas of potential vulnerability, but there are no signs of abuse or neglect. Client [R3] does not appear to pose a threat to other vulnerable adults." R4 R4's diagnoses included type 2 diabetes mellitus, chronic kidney disease, depression disorder and urinary incontinence. On September 13, 2022, at approximately 7:40 a.m., the surveyor observed ULP-D administer medications to R4. R4's Vulnerability Assessment/Abuse Prevention Plan, dated November 30, 2021, identified the following vulnerabilities among which included visual difficulties, pain, history of falls, and anxiety/depression. Item no. 27 of the plan indicated R4 "has some identified areas of potential vulnerability, but there are no signs of abuse or neglect."	0 630		

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0 630	Continued From page 9 On September 14, 2022, at approximately 10:59 a.m., LALD/RN-A verified the abuse prevention plan lacked assessment for R3 and R4's susceptibility to abuse by another individual including other vulnerable adults and lacked assessment of R4's risk of abusing other vulnerable adults. LALD/RN-A further stated this assessment was used for all the current residents. The licensee's Vulnerable Adult Reporting - Assisted Living Licensure policy, dated August 1, 2021, indicated its philosophy was to provide quality long-term care and ensure residents were not subjected to abuse by anyone, including, but not limited to facility staff, other residents, consultants, volunteers, staff of other agencies serving the individual, family members, friends or self-abuse. The policy indicated residents with services were assessed through the pre-admission medical screening process for susceptibility to abuse by individuals and their risk of abusing others. The assessment included risk of self-abuse. Further, the policy directed, plans were developed, and measures taken to minimize risks and ongoing assessments were completed with each 90-day evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 10 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 interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health. The licensee failed to ensure screening for active TB with either a two-step tuberculin skin test (TST), blood test or other evidence was completed and documented for three of three employees, unlicensed personnel (ULP)-D, ULP-E and ULP-F. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	0 660		

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0 660	Continued From page 11 The facility TB risk assessment, dated January 1, 2022, indicated low risk for TB transmission. ULP-D ULP-D was hired March 11, 2021. ULP-D's employee record had documentation of a single-step TST, dated March 14, 2021. ULP-D's employee record lacked evidence of a required second step TST, blood test or other documentation of active TB screening. ULP-E ULP-E was hired March 11, 2021. ULP-E's employee record lacked a documented TB history and symptoms screen and evidence of a TST, blood test or other documentation of active TB screening. ULP-G ULP-G was hired May 13, 2021. ULP-G's employee record included a TB Baseline Screening Tool for Health Care Workers, which included a TB history and symptoms screen completed January 27, 2022. The first TST, read January 29, 2022, was negative. ULP-G's record lacked evidence the employee received a required second TST, blood test or other documentation of active TB screening. On September 14, 2022, at approximately 3:51 p.m., licensed assisted living director/registered nurse (LALD/RN)-A acknowledged the employee TB records may be missing and said "we obviously have a weakness here." LALD/RN-A	0 660		

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0 660	Continued From page 12 said their employee records were "kind of a mess" and if there was no further information provided from HR (human resources) then "I would assume the TB documentation is missing from the records." The licensee's Tuberculosis Screening-Healthcare Worker policy dated August 2009, indicated all healthcare workers will receive baseline TB screening. The screening will include a written assessment of TB Risk factors, any current TB symptoms, and a two-step TB skin test or a blood test. 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 a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients 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 (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 13 (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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all required content. In addition, the licensee failed to ensure its missing person policy included all required content and was reviewed at least quarterly. This had the potential to affect all 37 residents, staff and any visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 680		

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0 680	Continued From page 14 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: During the entrance conference on September 13, 2022, at approximately 11:27 a.m., the surveyor requested to view the licensee's emergency preparedness (EP) plan and missing resident plan. Licensed assisted living director/registered nurse (LALD/RN)-A provided the surveyors with two different EP plans and numerous documents. The first plan provided was an 80 plus page document titled "Emergency Preparedness Planning and Resource Manual" and consisted of two main sections: Hazard and Security Vulnerability Assessment and Emergency Response. Each section had [the facility's name] typed in on spaces marked "facility name." Although the document, which had a copyright date of 2009, revised 2012, contained emergency planning information, it was not aligned with Appendix Z, the state-adopted EP guidelines, and lacked requirements of Appendix Z and facility-specific EP elements. This EP plan document lacked evidence it was ever dated or reviewed by the provider. A second EP plan was in a three-ringed binder which contained documents, policies and procedures. The documents included fire procedures (when to call 911, fire drills, using an extinguisher) and other procedures (missing client, sever weather/tornado emergency, flooding protocol, evacuation, loss of power, heat	0 680		

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0 680	Continued From page 15 exhaustion and heat stroke, water shortage, active shooter, bomb threat, among others. It was not clear to the surveyors this plan was tailored for the provider, as the evacuation plan listed the licensee as the evacuation site. The policies and procedures in this EP lacked evidence they were reviewed as part of the licensee's EP plan. Additionally, LALD/RN-A provided a Hazard and Vulnerability Assessment (HVA) Tool. The tool identified vulnerabilities and hazards, but lacked an analysis of which specific vulnerabilities could be faced by the licensee. The assessment tool was not dated. The licensee lacked an emergency preparedness plan to address the following requirements: -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies/procedures, based on assessment; and additional policies for: -handling medical documents; -handling and use of volunteers; -arrangement with other faculties or entities; -development of a communication plan, including: -names and contact information for staff, resident's physicians; (partial listing was found in provided documents); -emergency officials contact information for federal, stated tribal, regional & local EP staff; -primary and alternate means for communication; -methods for sharing information; -sharing information on occupancy and needs; and	0 680		

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0 680	Continued From page 16 -family notifications. -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. The licensee's Wandering or Missing Resident policy, dated July 15, 2021, lacked indication the plan was reviewed, with any documented changes, at least quarterly. On September 14, 2022, at approximately 3:53 p.m., LALD/RN-A stated their EP plan "has made me pull my hair out" and "this is my weak area." LALD/RN-A said she felt they had the required policies but could not fully explain the plan when the survey questioned why there were different versions of the EP plan and the lack of components tailored to the facility. LALD/RN-A said the plan needed additional work. In a subsequent interview on September 15, 2022, at approximately 1:25 p.m., LALD/RN-A said they had to implement their EP plan and evacuate some residents as a result of a power outage. However, LALD/RN-A added that aside from required monthly drills, there was no documentation of the events testing the plan. LALD/RN-A did not provide evidence the missing person plan was reviewed and/or updated at least quarterly. The licensee's Assisted Living Emergency Preparedness policy, dated August 2, 2021, indicated it is the intent that each assisted living facility has in place an effective and complaint emergency preparedness plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid services State Operation Manual Appendix Z. The policy indicated key elements of the plan included four primary components: 1.	0 680		

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0 680	Continued From page 17 Risk assessment and planning; 2. Policies and procedures; 3. A communication plan; 4. Staff training and exercise/drills. The policy indicated the facility will utilize a HVA tool, have policies and procedures designed to align with Appendix Z, and a communication plan. Further, the policy directed all staff receive annual training on the EP plan and the facility will conduct, at minimum, two EP drills (not including fire and evacuation drills), at least one a full-scale every 12 months to test the emergency plan. The licensee's Wandering or Missing Resident policy, revised July 15, 2021, identified responsibility to implement the policy was assisted living staff. The policy lacked indication and evidence the licensee's missing resident plan was reviewed and any changes documented by the licensed assisted living and nursing clinical nurse supervisor at least quarterly. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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:	0 800		

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0 800	Continued From page 18 Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on September 15, 2022, at approximately 11:30 a.m. with Licensed Assisted Living Director/ Registered Nurse (LALD/ RN)-A and Regional Maintenance Director (RMD)-L the following deficient items were observed: The emergency egress light in the lower-level corridor of unlocked unit was not working. There were several large holes from repairs in the fire rated walls of the laundry room in the memory care unit. LALD/RN-A and RMD-L visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		

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0 810	Continued From page 19	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the	0 810		

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0 810	Continued From page 20	0 810		

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

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

Findings include:

A record review and interview were conducted on September 15, 2022, at approximately 11:30 a.m. with Licensed Assisted Living Director/ Registered Nurse (LALD/ RN)-A and Regional Maintenance Director (RMD)-L on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.

Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. During interview, LALD/RN-A and RMD-L verified that the fire safety and evacuation plan for the facility lacked these provisions.

Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD/RN-A and RMD-L verified that the fire safety and evacuation plan for the

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0 810	Continued From page 21 facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did include procedures for resident movement, evacuation, or relocation during a fire or similar emergency but did not include the identification of unique or unusual resident needs for movement or evacuation. During interview, LALD/RN-A and RMD-L verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. During interview, RMD-L stated that training was provided annually to employees after orientation but did not have documentation or a policy on employee training of the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, LALD/RN-A and RMD-L stated that the facility did not have documentation or a policy on resident training of the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that no drills were conducted by the licensee for the facility. During interview, RMD-L stated there were no	0 810		

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0 810	Continued From page 22 documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;	0 940		

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0 940	Continued From page 23 (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R1, R3, R4). This had potential to affect 37 residents of the facility. 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, R3 and R4's assisted living contracts lacked a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: -whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); and -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required. R1	0 940		

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0 940	Continued From page 24 R1's service plan, dated June 6, 2022, indicated R1 received services including meals, assistance with activities of daily living, housekeeping and laundry and medication/treatment management. R1's assisted living contract was signed by the resident's representative on May 10, 2022. R3 R3's service plan, dated September 12, 2022, indicated R3 received services including meals, reassurance checks, cueing, transferring assist of one, medication administration, housekeeping and laundry services. R3's assisted living contract was signed by R3 on October 25, 2021. R4 R4's service plan, dated November 30, 2021, indicated R4 received services including meals, reassurance checks, cueing, blood sugar checks, medication administration, housekeeping and laundry services. R4's assisted living contract was signed by R4 on November 24, 2021. On September 14, 2022, at approximately 10:58 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she went through the contract, acknowledged the items listed above relating to when a resident uses public assistance and said the items "were not in the contract." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		

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0 950	Continued From page 25	0 950		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content to allow residents to name or choose not to name a designated representative for three of three	0 950		

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0 950	Continued From page 26 residents (R1, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's, R3's and R4's assisted living contracts lacked a notice with the required statutory language regarding the option to identify a designated representative or have a box/space for the resident to initial if the resident declined to name a representative. R1 R1's service plan, dated June 6, 2022, indicated R1 received services including meals, assistance with activities of daily living, housekeeping and laundry and medication/treatment management. R1's assisted living contract was signed by the resident's representative on May 10, 2022. R1's assisted living contract lacked the content listed above. R3 R3's service plan, dated September 12, 2022, indicated R3 received services including meals, reassurance checks, cueing, transferring assist of one, medication administration, housekeeping and laundry services. R3's assisted living contract was signed by R3 on October 25, 2021. R3's assisted living contract	0 950		

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0 950	Continued From page 27 lacked the content listed above. R4 R4's service plan, dated November 30, 2021, indicated R4 received services including meals, reassurance checks, cueing, blood sugar checks, medication administration, housekeeping and laundry services. R4's assisted living contract was signed by R4 on November 24, 2021. R4's assisted living contract lacked the content listed above. On September 14, 2022, at approximately 12:09 p.m., licensed assisted living director/registered nurse (LALD/RN)-A reviewed the resident admission packet, including contract, with the surveyors. LALD/RN-A acknowledged that although they offer the resident to list and include contact information of their designated representative, the contract itself did not include a box or space for the resident to initial if they decline to name a representative. LALD/RN-A also acknowledged the required text explaining options regarding the naming of a representative was not in the contract or admission packet and said, "We don't have that." LALD/RN-A confirmed the same admission packet and contract was used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a	01060		

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01060	Continued From page 28 resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.	01060		

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01060	Continued From page 29 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and also failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R7). 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: R7 was admitted for assisted living with dementia care services on March 7, 2022. R7's Assisted Living Agreement Addendum, dated March 9, 2022, indicated R7 received the following services: medication administration, assistance with bathing, toileting, dressing, grooming, escorts to and from meals, reassurance checks, housekeeping, and laundry. R7's progress note dated May 20, 2022, indicated the licensee sent R7 to the emergency room at a nearby hospital for evaluation and a later note indicated R7 was admitted to the hospital. A progress note dated May 23, 2022, indicated R7 now required more assistance with transfers and would most likely be discharged to a rehabilitation facility. A progress note dated June 3, 2022, indicated R7's family notified the facility that R7	01060		

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01060	Continued From page 30 was no longer fit for the facility and was being discharged to another assisted living facility. R7's discharge summary dated June 3, 2022, indicated R7 had to move to a higher level of care. Although R7 was relocated from the facility longer than four days, R7's record lacked a written emergency relocation notice that contained, at a minimum: - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R7's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. On September 14, 2022, at approximately 3:34 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she did not feel a notice was necessary for R7, as in this case the move to the ER and subsequent hospitalization was not an emergency relocation, but rather a "continuance of care." LALD/RN-A said were this an emergency situation, she would have provided	01060		

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01060	Continued From page 31 a notice to the resident, family and the Ombudsman, but did not implement that here and did not feel it was an emergency relocation. The licensee's Emergency Relocation Policy, dated August 1, 2021, indicated emergency relocation is deemed not a termination yet a relocation in best interest of the resident. In the event of an emergency relocation, the facility must provide written notice that contains the elements listed above. The policy also indicated the required notice must be delivered as soon as practicable to the resident, legal representative and designated representative and the Office of Ombudsman for Long-Term Care, if the resident has been relocated and not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff	01440		

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01440	Continued From page 32 administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse supervised staff within 30 days after performing delegated nursing tasks for two of two employees, unlicensed personnel (ULP)-D and ULP-E. 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: During the entrance conference on September 12, 2022, at approximately 11:01 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated unlicensed staff performed delegated tasks, including medication administration and treatments. ULP-D ULP-D started employment on March 11, 2021.	01440		

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01440	Continued From page 33 On September 12, 2022, between approximately 2:20 p.m. and 2:49 p.m., the surveyor observed ULP-D administer medications to residents on the assisted living second floor. On September 12, 2022, at approximately 2:20 p.m., ULP-D told the surveyor the RN trained her to pass out medications. ULP-D's employee record lacked evidence the registered nurse supervised ULP-D within 30 days after performing delegated tasks. ULP-E ULP-E started employment on March 11, 2021. On September 13, 2022, between approximately 8:15 a.m. and 8:36 a.m., the surveyor observed ULP-E administer oral medications to three residents on the locked memory unit. On September 13, 2022, at approximately 8:59 a.m., ULP-E told the surveyor she had been trained by the nurse to pass out medications and did that every day when she was assigned as the medication passer. ULP-E's employee record lacked evidence the registered nurse supervised ULP-E within 30 days after performing delegated tasks. On September 14, 2022, at approximately 3:40 p.m., licensed assisted living director/registered nurse (LALD/RN)-A said they had been doing internal audits of employee records regarding supervisions by the RN and orientation and the documentation was lacking. LALD/RN-A admitted the missing staff observations were not limited to just these two staff.	01440		

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01440	Continued From page 34 The licensee's Supervision of ULP policy, dated December 2019, indicated staff providing delegated nursing or therapy home care tasks at the facility will be supervised by an RN periodically where the services are being provided to verify that work is being performed competently and to identify problems and solutions to the staff's ability to perform the tasks. Supervision would include the observation of the staff administering the medication or treatment and the interaction with clients. Further, the policy directed the ULP must be supervised by an RN within 30 days after the date on which the individual begins working for the home care provider and first performs delegated tasks and thereafter as needed. Also, documentation of supervision activities must be retained in employee personnel records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced	01460		

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01460	Continued From page 35 by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations with all required content for one of three employees, unlicensed personnel (ULP)-G. 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 September 12, 2022, at approximately 10:47 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she was familiar with the statutes and regulations for assisting living. LALD/RN-A verified the facility held an assisted living with dementia care license. ULP-G was hired May 13, 2021, to provide direct care services to the licensee's residents. On September 13, 2022, at approximately 6:43 a.m., the surveyor observed ULP-G assist R1 with toileting and transferring, then later placed a C-PAP (continuous positive airway pressure device, used to treat sleep apnea disorders) when R1 returned to the recliner. ULP-G's employee record lacked evidence the employee completed orientation to assisting living	01460		

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01460	Continued From page 36 facility requirements to include: - overview of Assisted Living statutes; - review of provider's policies and procedures; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors; - review of the assisted living bill of rights; - handling of resident complaints; - consumer advocacy services; - review of the type of assisted living services the employee will provide; and - principle of person-centered planning/service delivery. On September 14, 2022, at approximately 3:40 p.m., LALD/RN-A said it was their standard to not allow new employees to work the floor until they've completed the assisted living overview. LALD/RN-A said they audited employee records and acknowledged elements of orientation were lacking, including for ULP-G. The licensee's Orientation of Assisted Living Staff policy, dated August 1, 2021, indicated all staff providing and supervising assisted living services must complete an orientation to assisted living requirements and regulations before providing services to residents. The policy listed topics for orientation, which included those identified above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01470 SS=D	144G.63 Subd. 2 Content of required orientation	01470		

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01470	Continued From page 37 (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must	01470		

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01470	Continued From page 38 include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations with all required content for one of three employees unlicensed personnel (ULP)-E. 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 September 12, 2022, at approximately 10:47 a.m., licensed assisted living director/registered nurse	01470		

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01470	Continued From page 39 (LALD/RN)-A stated she was familiar with the statutes and regulations for assisting living. LALD/RN-A verified the facility held an assisted living with dementia care license. ULP-E was hired March 11, 2021, to provide direct care services to the licensee's residents. On September 13, 2022, between approximately 8:15 a.m. and 9:20 a.m., the surveyor observed ULP-E administer morning medications to residents on the secured memory-care unit. ULP-E's employee record lacked evidence the employee's orientation to assisting living facility requirements included: - an overview of assisted living statutes; - review of provider's policies and procedures; - review of the assisted living bill of rights; - handling of resident complaints; - consumer advocacy services; - review of the type of assisted living services the employee will provide; and - principle of person-centered planning/service delivery. On September 14, 2022, at approximately 3:40 p.m., LALD/RN-A said it was their standard to not allow employees to work the floor until they've completed the assisted living overview. LALD/RN-A said they audited employee records and acknowledged elements of orientation were lacking, including for ULP-E. The licensee's Orientation of Assisted Living Staff policy, dated August 1, 2021, indicated all staff providing and supervising assisted living services must complete an orientation to assisted living requirements and regulations before providing services to residents. The policy listed topics for	01470		

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01470	Continued From page 40 orientation, which included those identified above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff received required dementia care training in the required time frame for two of two employees, unlicensed personnel (ULP)-D and ULP-E. This had the potential to affect all thirty-seven residents.	01540		

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01540	Continued From page 41 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 finding include: ULP-D ULP-D started employment on March 11, 2021. On September 12, 2022, between approximately 2:20 p.m. and 2:49 p.m., the surveyor observed ULP-D administer oral medications to two residents on the assisted living second floor. On September 12, 2022, at approximately 2:20 p.m., ULP-D told the surveyor the RN had trained her to pass out medications. ULP-D's record indicated the employee did not complete eight (8) required hours of training in dementia care within 80 hours of the employee's start date. The record indicated ULP-D completed only 2.5 hours of dementia training as of September 14, 2022. ULP-E ULP-E was hired March 11, 2021, to provide direct care services to the licensee's residents. On September 13, 2022, between approximately 8:15 a.m. and 8:36 a.m., the surveyor observed ULP-E administer medications to three residents on the locked memory unit. ULP-E's record indicated the employee did not	01540		

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01540	Continued From page 42 complete eight (8) required hours of training in dementia care within 80 hours of the employee's start date. The record indicated ULP-E completed just 3.5 hours of dementia training as of September 6, 2022. On September 14, 2022, at approximately 3:46 p.m., licensed assisted living director/registered nurse (LALD/RN)-A acknowledged staff have not completed all required hours of dementia training and stated moving forward they would work to correct this shortcoming. LALD/RN-A also said it was likely other staff were not up-to-date with their dementia training. The licensee's Training Requirements for Assisted Living with Dementia Care, undated, the facility will ensure that staff who provide support to residents with dementia can demonstrate a basic understanding and ability to apply dementia training to the resident's emotional and unique health needs using person-centered planning delivery. The policy directed direct-care employee must have completed at least eight hours of initial training on topics specified within 160 working hours of employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620		

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01620	Continued From page 43 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed comprehensive re-assessments accurately or timely for three of three residents (R1, R3, R4). In addition, the licensee failed to ensure the uniform assessment tool included all required content for three of three residents (R1, 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) 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).	01620		

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01620	Continued From page 44 The findings include: ASSESSMENTS INACCURATE AND NOT COMPLETED TIMELY R1 R1's record lacked evidence an accurate 90-day reassessment was completed after a change of condition. R1's diagnoses included dementia, hypertension, chronic respiratory failure, stage 3 chronic kidney disease, hyperlipidemia, type 2 diabetes, edema and neuropathy. R1's Assisted Living Agreement Addendum, dated June 22, 2022, indicated R1 received services including: assistance with bathing, assistance with dressing and application of TED (anti-embolism) hose, medication administration, laundry, housekeeping and reassurance checks. R1's initial assessment dated May 10, 2022, indicated in #27 of the form that R1 had no skin issues at this time. On September 13, 2022, at approximately 10:55 a.m., a home care agency registered nurse (HCRN)-K entered R1's room, stating she was going to provide wound care for R1. HCRN-K stated R1 current had two open sores located near R1's coccyx. R1's record included Care Communication Notes, dated September 9, 2022, and September 13, 2022, that indicated wound care was completed by home care agency staff. A nursing progress note dated July 27, 2022,	01620		

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01620	Continued From page 45	01620		

written by licensed practical nurse (LPN)-B indicated R1 was seen by home health care agency and wound care was completed. Other notes written by LPN-B on August 9, 2002, August 112, 2022 and September 13, 2022 also indicated the home health care agency completed wound care for R1.

R1's 90-day assessment, completed and signed by licensed assisted living director/registered nurse (LALD/RN)-A on August 5, 2022, indicated the most recent RN assessment was reviewed in its entirely and no deviations noted, and also no new skin concerns noted.

On September 15, 2022, at approximately 1:43 p.m., LALD/RN-A said R1 was being seen for wound care by an outside home health agency, that R1's 90-day assessment was not accurate and did not indicate R1 had pressure ulcer.

R3
R3's diagnoses included chronic pain syndrome, anxiety disorder, major depressive disorder, and COPD (chronic obstructive pulmonary disease.)

R3's service plan, dated September 12, 2022, indicated R3 received services including meals, reassurance checks, cueing, transferring assist of one, medication administration, housekeeping and laundry services.

On September 13, 2022, at approximately 8:10 a.m., the surveyor observed ULP-D measure R3's oxygen saturation, which was 97 % on 3 liters per minute (LPM) of oxygen per nasal cannula.

R3's record included an RN Assessment (Initial/Change of Condition) dated November 30,

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01620	Continued From page 46 2021. The next reassessment in R3's record was dated April 12, 2022, more than four months or 133 days later. R3's record lacked RN assessment at least every 90-days as required. R4 R4's diagnoses included type 2 diabetes mellitus, chronic kidney disease, depression disorder and urinary incontinence. R4's service plan, dated November 30, 2021, indicated R4 received services including meals, reassurance checks, cueing, blood sugar checks, medication administration, housekeeping and laundry services. On September 13, 2022, at approximately 7:40 a.m., the surveyor observed ULP-D measure R4's blood sugar, which was 88 (milligrams per deciliter). R4's record included an RN Assessment (Initial/Change of Condition) dated November 29, 2021. R4's record did not contain every 90-day assessment by an RN as required. R4's record contained a late 90-day reassessment dated April 7, 2022, which was due on or before March 10, 2022. UNIFORM ASSESSMENT TOOL LACKED COMPONENTS R1's, R4, and R3's initial assessments lacked evidence the uniform assessment tool used by the facility included all required areas review. During the entrance conference on September 12, 2022, at approximately 11:00 a.m., licensed assisted living director/registered nurse (LALD/RN)-A talked about their assessment	01620		

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01620	Continued From page 47 process and said they used a computer form as the assessment tool. On September 12, 2022, at approximately 8:40 a.m. the surveyors questioned LALD/RN-A about missing content in resident assessments. LALD/RN-A stated they used a computer form when doing the assessments and was sure it contained all required areas. LALD/RN-A explained that if a resident no identified concerns or if an assessment area did not trigger, that section on the form would not print out so to speak, but was still assessed. LALD/RN-A said she would email a blank copy of the uniform assessment tool they use, which was later provided to the surveyors and reviewed. R1's, R3, and R4's records lacked evidence of assessment for: -advanced health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not attempt resuscitation order" or "physician/provider orders for life sustaining treatment" order; -review of medical, dental and emergency room visits in the past 12 months and care from a post-acute care facility; -review of any reports from a physical, occupational or speech therapist in the past 12 months; -list of treatments, including type, frequency and level of assistance needed; -the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and -who has decision-making authority of a substitute decision maker. On September 14, 2022, at approximately 10:11 a.m. LALD/RN-A discussed resident	01620		

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01620	Continued From page 48 assessments with the surveyors. LALD/RN-A stated she felt the assessment tool used met the requirements as it had already been reviewed in a state survey. LALD/RN-A realized that the specific words or assessment areas the surveyors pointed out may not be on the form but said the tool they used included space at the end of the form to address any other concerns. The licensee's Assessments - Schedule Policy, dated August 26, 2021, indicated the RN must review most recent past RN assessment and if noting any deviation or change since last assessment, the RN must complete RN assessment using the uniform assessment format. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care.	01640		

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01640	Continued From page 49 (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 interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for two of three residents (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 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R3 R3 was admitted November 30, 2021, and had diagnoses including chronic pain syndrome, anxiety disorder, major depressive disorder, and COPD (chronic obstructive pulmonary disease.) R3's service agreement dated September 12, 2022, lacked a signature or other authentication	01640		

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01640	Continued From page 50 by the resident or by the facility, documenting agreement on the services to be provided. R4 R4 was admitted December 7, 2021, and had diagnoses including type 2 diabetes mellitus, chronic kidney disease, depression disorder and urinary incontinence. R4's service agreement dated November 30, 2021, lacked a signature or other authentication by the resident or by the facility, documenting agreement on the services to be provided. On September 13, 2022, at 10:25 a.m., licensed assisted living director/registered nurse (LALD/RN)-A verified R3 and R4's current service plan did not include a signature by the facility, resident or resident's representative. LALD/RN-A further stated she knows this is a regulation and was working to address this. The licensee's Service Plan Policy, dated November 2019, indicated, the service plan and any revisions must include a signature or other authentication by the Assisted Living and by the resident or the resident's representative documenting agreement on the services to be provided. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01640		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	01890		

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01890	Continued From page 51 the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, licensee failed to ensure time-sensitive medications were dated when opened for one of three residents (R2) 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 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included chronic cough, atrial fibrillation, anxiety, type 2 diabetes, esophageal reflux, hypertension and dementia. R2's Assisted Living Agreement Addendum, dated September 24, 2021, indicated R2 received medication management services. R2's prescriber's orders dated June 22, 2022, indicated R2 received Symbicort Aerosol (budesonide 160 mcg/formoterol fumarate 4.5 mcg), two puffs by moth twice daily. On September 13, 2022, at approximately 8:36	01890		

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01890	Continued From page 52 a.m. the surveyor observed ULP-E give R2 the Symbicort inhaler and instructed the resident to take the medication. R1's opened inhaler lacked a date the inhaler was removed from the foil packaging. On September 13, 2022, at approximately 2:15 p.m., ULP-E verified R1's Symbicort medication did not have an open date on either the inhaler or the package where it was stored. ULP-E stated medications like nose spray, powders, inhalers, eye and ear drops and insulin pens were supposed to be dated when we open them and it looked like R1's inhaler was not. On September 14, 2022, at approximately 11:09 a.m., licensed assisted living director/registered nurse (LALD/RN)-A said she expected time-sensitive medications to be dated once opened. LALD/RN-A said there were stickers on the medication packages for labeling and staff were supposed to date R1's inhaler medication. The manufacturer's instructions for the Symbicort Inhalation Aerosol inhaler, revised December 2017, directed to discard the inhaler when the counter reaches zero (0) or three (3) months after opening the foil tray. The licensee's Labeling of Medication policy, dated December 2019, indicated all medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations. The policy also indicated medications, such as insulin pens, should be labeled with dated when opened. No further information was provided.	01890		

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01890	Continued From page 53 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	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 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:	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30675	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS EDGE ASSISTED LIVING	77 STADIUM ROAD MANKATO, MN 56001

(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
01940	Continued From page 54 Based on observation, interview and record review, the licensee failed to develop an individualized treatment and therapy management plan with required content for three of three residents (R1, R4, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on September 12, 2022, at approximately 11:01 a.m., licensed assisted living director/registered nurse (LALD/RN)-A confirmed the licensee provided treatment and therapy services to residents as prescribed. R1's, R3's and R4's record lacked evidence an individualized treatment or therapy management plan was developed for the residents' treatments that contained required content, including: - a statement of the type of services that would be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to ULP; - procedures for notifying a RN 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,	01940		

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01940	Continued From page 55 verification that all treatment or therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R1 R1's diagnoses included dementia, hypertension, chronic respiratory failure, stage 3 chronic kidney disease, hyperlipidemia, type 2 diabetes, edema and neuropathy. R1's Assisted Living Agreement Addendum, dated June 22, 2022, indicated R1 received services including: assistance with bathing, assistance with dressing and application of TED (anti-embolism) hose, medication administration, as-needed application of a BiPap (breathing assistance device), weekly blood glucose checks, escorts to meals, laundry, housekeeping and reassurance checks On September 13, 2022, at approximately 6:43 a.m., the surveyor observed ULP-G escort R1 back to the recliner in the resident's room. ULP-G placed the BiPap back on the resident, and checked the oxygen flow rate, which was 2 liters per minute. Later, at approximately 10:18 a.m., ULP-E placed compression garments on R1's legs bilaterally. At approximately 10:55 a.m., home care provider registered nurse (HCRN)-K said she was going to change dressings on R1's coccyx wound. On September 13, 2022, at approximately 11:06 a.m., ULP-E verified the home care nurse came to check on R1's wound, but staff here monitor R1's dressing on days when the nurse does not come. ULP-E said she checked the dressing	01940		

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	30675	A. BUILDING: _____ B. WING _____	09/15/2022

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01940	Continued From page 56	01940		

every day and would tell the nurse if the dressing was soiled, moved, or if it was off and needed changing. ULP-E said she made sure R1 changed position frequently when in the recliner and placed a pillow to keep R1 off her bottom. ULP-E said that information "was not on the iPad," but the nurse talked to us about it.

R1's record lacked evidence of an individualized treatment or therapy management plan for the resident's scheduled BiPAP, oxygen use, compression sock and wound care that included all required content listed above.

R4

R4's diagnoses included type 2 diabetes mellitus, chronic kidney disease, depression disorder and urinary incontinence.

R4's service plan, dated November 30, 2021, indicated R4 received services including meals, reassurance checks, cueing, blood sugar checks, medication administration, housekeeping and laundry services.

On September 13, 2022, at approximately 7:40 a.m., the surveyor observed ULP-D measure R4's blood sugar.

R4's record lacked evidence of an individualized treatment or therapy management plan for the resident's scheduled blood glucose checks that included all required content as listed above.

R3

R3's diagnoses included chronic pain syndrome, anxiety disorder, major depressive disorder, and COPD (chronic obstructive pulmonary disease.)

R3's service plan, dated September 12, 2022, indicated R3 received services including meals,

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	30675	A. BUILDING: _____ B. WING _____	09/15/2022

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01940	Continued From page 57	01940		

reassurance checks, cueing, transferring assist of one, medication administration, housekeeping and laundry services.

On September 13, 2022, at approximately 8:10 a.m., the surveyor observed ULP-D measure R3's oxygen saturation, which was 97 % on 3 liters per minute of oxygen per nasal cannula.

R3's record lacked evidence of an individualized treatment or therapy management plan for the resident's scheduled oxygen use that included required content described above.

On September 14, 2022, at approximately 3:53 p.m., LALD/RN-A said the information for the treatment plans was in the assessment, service agreement addendum and some may be on the MAR. LALD/RN said some treatment information was in different areas in the resident records, but acknowledged their treatment plan did not have all required content. LALD/RN-A also verified there was no unique treatment management form and their assessment form did not include the content for treatment management.

The licensee's Development of the Individualized Medication, Treatment and Therapy Management Plan and Individualized Medication and Treatment Record policy, dated November 2019, directed, based on the comprehensive nursing assessment, the RN develops in individualized medication and treatment plan for each client the plan, which will be part of the client's service plan. The RN will develop the client's medication and treatment record with detailed information about the medications and treatments staff will be managing. The policy indicated plan will address items identified above. Further, the RN asks the client/representative to sign the Individualized

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01940	Continued From page 58 Management or Treatment/Therapy Management Plan when the service plan is signed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
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 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 record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	02040		

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	30675	A. BUILDING: _____ B. WING _____	09/15/2022

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02040	Continued From page 59 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on September 15, 2022, at approximately 11:30 a.m. with Licensed Assisted Living Director/ Registered Nurse (LALD/ RN)-A and Regional Maintenance Director (RMD)-L on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD/RN-A and RMD-L verified that the licensee had not conducted a hazard vulnerability assessment for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision.	03090		

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03090	Continued From page 60 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not 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 finding include: On September 12, 2022, at approximately 12:00 p.m., the surveyors toured the facility's main entry and common areas and noted the signage posted regarding electronic monitoring lacked the required verbiage. The licensee's "Electronic Monitoring Requirements in Minnesota" signage posted on the assisted living entrance door and inside front entrance of the assisted living indicated, "Electronic Monitoring means the use of a device, such as a camera or other device that captures, records, or broadcasts audio, video, or both, that is placed in a resident's room or private living unit and is used to monitor the resident or activities in the room or private living space." On September 14, 2022, at approximately 11:06 a.m., licensed assisted living director/registered	03090		

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03090	Continued From page 61 nurse (LALD/RN)-A verified the signs posted included the above content, but lacked required statutory language. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *09/14/22*
Time: 12:05:34
Report: 1028221144

Food and Beverage Establishment Inspection Report

Location:
Laurels Edge Assisted Living
77 Stadium Road
Mankato, MN56001
Blue Earth County, 07

Establishment Info:
ID #: 0032009
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Monarch Healthcare Management

Phone #: 5073872133
ID #: 47490

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ** Priority 1 **

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

Reports of diarrhea or vomiting made by food employees are currently not being notified to the State at 1-877-Food-ILL (1-877-366-3455).

Comply By: 09/15/22

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 the Fridigaire Refrigerator must be discarded as the temperature was recorded at 48 degrees F. The refrigerator must be adjusted such that it maintains cold food at 41 degrees F or below. If this is not possible, the refrigerator must be replaced

Comply By: 09/15/22

2-100 Supervision

2-102.12AMN

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

A Certified Food Protection Manager must be employed by this establishment as soon as possible.

Comply By: 09/15/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

A handwashing sign must be provided at the handwashing sink in the service area.

Comply By: 09/15/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

Damaged countertops in the service area next to the handwashing sink must be repaired or replaced.

Comply By: 09/15/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

The floor surfaces throughout the kitchen and service area must be cleaned to remove dirt, water, and food debris build-up.

Comply By: 09/15/22

Surface and Equipment Sanitizers

Hot Water: = at 177 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: -7 Degrees Fahrenheit - Location: Atosa
Violation Issued: No

Process/Item: Hot Holding
Temperature: 150 Degrees Fahrenheit - Location: Potatoes
Violation Issued: No

Process/Item: Hot Holding
Temperature: 150 Degrees Fahrenheit - Location: Roast Beef
Violation Issued: No

Process/Item: Cold Holding
Temperature: 48 Degrees Fahrenheit - Location: Milk
Violation Issued: Yes

Type: Full
Date: *09/14/22*
Time: 12:05:34
Report: 1028221144
Laurels Edge Assisted Living

Food and Beverage Establishment Inspection Report

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

This Inspection was conducted in conjunction with HRD.

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028221144 of 09/14/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Tony Chalhoub
Culinary Director

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