DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

January 3, 2023

Licensee
Colony Court Memory Care
500 22nd Avenue Northwest
Waseca, MN 56093

RE: Conditional License Number 408358
Health Facility Identification Number (HFID) 28411
Project Number SL28411015

Dear Licensee:

On December 20, 2022, The Minnesota Department of Health (MDH) completed a follow-up evaluation of your facility to determine correction of orders found on the licensing evaluation completed on September 1, 2022. The follow-up evaluation found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective January 3, 2023.

Furthermore, the follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the September 1, 2022, initial evaluation.

The details of the violations noted at the time of this follow-up evaluation completed on December 20, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left-hand column, e.g., {2 ----} will identify the uncorrected tags.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint evaluation, and as otherwise needed. 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. 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 addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
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 Jodi Johnson at jodi.johnson@state.mn.us or 507-344-2730.

Sincerely,

Maria King

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28411	A. BUILDING: _____ B. WING _____	R 12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY COURT MEMORY CARE	500 22ND AVENUE NW WASECA, MN 56093

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL28411015-1 On December 19, 2022, through December 20, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on September 1, 2022. At the time of the survey, there were 16 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{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.	
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	{0 810}		

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{0 810}	Continued From page 1 (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: NO FURTHER ACTION NEEDED	{0 810}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	{01640}		

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{01640}	Continued From page 2 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of four residents' (R18) service plans were revised to reflect the current services provided. 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	{01640}		

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{01640}	Continued From page 3 situation has occurred only occasionally). The findings include: R18's record lacked documentation the service plan was revised to include the service of daily blood sugar checks and the change in R18's diet from a pureed/ground consistency with thickened liquids to a regular diet with thin liquids. R18's diagnoses included Alzheimer's disease, type 2 diabetes (when the body cannot regulate blood sugar), hypertension, heart failure and atrial fibrillation (an irregular heartbeat). R18's (unnamed) Service Plan dated August 26, 2022, indicated R18 received services to include medication management, assistance with dressing, grooming, and bathing, meal assistance with food to be ground and liquids thickened. Additionally, the Service Plan indicated in section labeled Diabetes Management, "Other- provider helps with diabetes management. SPECIFY: Resident takes oral medication for Diabetes management. Staff will administer." The Service plan lacked the service of blood glucose checks completed daily by ULP (unlicensed personnel). R18's provider's order dated October 12, 2022, included an order for blood sugar checks daily and indicated a change in diet to advance to a regular diet. On December 20, 2022, at 8:15 a.m. ULP-O stated another ULP had already completed R18's blood sugar check as R18 had gotten up early. On December 20, 2022, at 1:00 p.m. the surveyor observed ULP-D to review the task list documentation screen on the tablet used to	{01640}		

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{01640}	Continued From page 4 document tasks performed. The task of R18's blood sugar check included a drop-down screen with specific directions for ULP to follow in performing a blood sugar check and also included parameters for when ULP should contact a nurse. On December 20, 2022, at 1:10 p.m. registered nurse (RN)-B stated R18's service plan should have included the service of a blood sugar check and the change to a regular diet with thin liquids. RN-B stated "usually the level of care (assessment) would capture the tasks which would then move to both the resident's service plan and task list. This does not always happen though, and the nurse will at times hand edit the task list to add the task and appropriate instructions. In this case it could be that the nurse missed checking to ensure the blood sugar service showed up in the service plan." Regarding the change in R18's diet from ground/pureed texture and thickened liquids to a regular diet with thin liquids, RN-B stated, "The Service plan should have been updated with that information. We are working to update all resident's service plans and are not there yet with this one." The licensee's Contents of service plans policy dated October 18, 2021, indicated Service plans are reviewed and revised as needed based upon on-going resident assessment. No further information was provided.	{01640}		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of	{01940}		

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{01940}	Continued From page 5 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: Based on observation, interview, and record review, the facility failed to include in the service plan a written statement of the treatment or therapy services that will be provided to one of four (R18) for blood sugar checks. This practice resulted in a level two violation (a violation that did not harm a resident's health or	{01940}		

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{01940}	Continued From page 6	{01940}		

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:

R18's (unnamed) Service plan dated August 26, 2022, indicated R18 received services to include medication management, assistance with dressing, grooming, and bathing, meal assistance with food to be ground and liquids thickened. R18's Service plan did not include the treatment of a daily blood sugar check.

R18's diagnoses included Alzheimer's disease, type 2 diabetes (when the body cannot regulate blood sugar), hypertension, heart failure and atrial fibrillation (an irregular heartbeat).

R18's provider's order dated October 12, 2022, indicated an order for blood sugar checks daily and indicated a change in diet to advance to a regular diet.

R18's Task list report dated December 20, 2022, included blood sugar-up to two times daily check. Scheduled every day at 8:00 a.m.

On December 20, 2022, at 8:15 a.m. unlicensed personnel (ULP)-O stated they had already completed R18's blood sugar check as R18 had gotten up early.

On December 20, 2022, at 1:00 p.m. the surveyor observed ULP-D to review the task list documentation screen on the tablet to include a

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{01940}	Continued From page 7	{01940}		

drop- down screen for specific directions for ULP to follow in performing a blood sugar check and also included parameters for when ULP should contact a nurse.

R18's record lacked a treatment plan to include the following required content:
-a statement of the type of services that will be provided;
-documentation of specific resident instructions relating to the
treatments or therapy administration;
-identification of treatment or therapy tasks that will be delegated to
unlicensed personnel; and
- any resident-specific requirements relating to documentation of
treatment and therapy received, verification that all treatment and
therapy was administered as prescribed, and monitoring of treatment or
therapy to prevent possible complications or adverse reactions.

On December 20, 2022, at 1:15 p.m. RN-B stated R18's record did not clearly indicate the required content of a treatment plan to include blood sugar monitoring. RN-B stated, "I am building the treatment plans into the assessment with the required content, but it's not there yet."

The licensee's Treatment Management Plan policy dated November 23, 2022, indicated the RN will assess the resident on pre-admission, admission, at 14-day, every 90-day and anytime there is a change in conditions. The RN will discuss with the resident what treatment/therapy they are receiving the reason for the treatment/therapy. The treatment or therapy services will be recorded on the service plan/task.

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{01940}	Continued From page 8 The RN will identify what treatment and therapies will be delegated to the unlicensed staff and train them on the treatment and therapy prior to having them perform the treatment/therapy. No further information is available.	{01940}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

FINE RESCINDED

Electronically Delivered

March 23, 2023

Administrator
Colony Court Memory Care
500 22nd Avenue Northwest
Waseca, MN 56093

RE: Conditional License Number 408358
Health Facility Identification Number (HFID) 28411
Project Number SL28411015

Dear Administrator:

Please note: Due to recent discussions by Department staff, we have implemented a change in how we assess fines. Specifically, the $3,000.00 fine related to the tag 3000 is being rescinded. No other changes have been made to this letter. If you have not already requested a reconsideration or hearing from the previous letter dated October 3, 2022, your ability to do so has expired.

The Minnesota Department of Health (MDH) completed a licensing evaluation on September 1, 2022 for the purpose of assessing compliance with state licensing statutes. Based on the licensing evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is issuing a 90 day conditional license due to expire on January 1, 2023.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00
St - 0 - 0620 - 144g.42 Subd. 6 (a) - Compliance With Requirements For Reporting Ma = $3,000.00

The total amount you are assessed is $3,500.00 You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

Conditional License Issued:
MDH will issue Colony Court Memory Care a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Colony Court Memory Care is in compliance.

The following conditions apply on the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Colony Court Memory Care will not admit any new residents under its conditional assisted living facility license until the MDH removes the "no new admissions" condition. Colony Court Memory Care must provide the Department:

    i. A list of the names and birthdates of any individuals Colony Court Memory Care is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents by location including:
        1. Name and birthdate of each resident
        2. Physical location of each resident
        3. Current payment source for services
        4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. **Consultant:** Colony Court Memory Care will contract with an RN to provide consultation concerning all resident(s) to whom Colony Court Memory Care provides licensed assisted living services under the conditional license. <u>The consultant must have access to all resident(s) receiving services from Colony Court Memory Care. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH</u>. The RN must not have any affiliation with Colony Court Memory Care and MDH must review the RN's credentials and approve the selection. Colony Court Memory Care is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Colony Court Memory Care in an effort to help Colony Court Memory Care align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral

and written reports to MDH noting progress toward compliance and/or concerns about observations. Colony Court Memory Care will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Colony Court Memory Care and the RN consultant about a change. Each report will be electronically submitted to Jodi Johnson, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at jodi.johnson@state.mn.us. Jodi Johnson can be reached at 507-344-2730 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of licensing orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Colony Court Memory Care to correct the violations cited during the evaluation as well as to determine the overall practice of Colony Court Memory Care in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. Follow-up Evaluation: At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. **Corrective Action Plan:** Colony Court Memory Care will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of correction work
    vi. Description of a plan to monitor and ensure ongoing compliance for each corrected order

Results of Follow-Up Survey During the Conditional License Period:
MDH will determine if Colony Court Memory Care is in compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license period. If MDH determines Colony Court Memory Care is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Colony Court Memory Care's assisted living facility license, and Colony Court Memory Care will correct violations identified during the evaluation to come into full compliance. If MDH determines Colony Court Memory Care is not in substantial compliance, MDH may take additional enforcement action against Colony Court Memory Care, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

Request a Hearing:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing should be addressed to:

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

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

If you have any questions, please contact Jodi Johnson directly at: 507-344-2730.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28411	A. BUILDING: _____ B. WING _____	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY COURT MEMORY CARE	500 22ND AVENUE NW WASECA, MN 56093

(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: SL28411015 On August 29, 2022, through September 1, 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 17 residents; all of whom who were receiving 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 Home Care/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 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	

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0 110	Continued From page 1	0 110		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD-A) was listed as the Director of Record for the licensee and had completed a shared license application for utilizing LALD-A's license for two separate (assisted living dementia care facility) building locations. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 29, 2022, at 11:09 a.m. LALD-A stated she was the housing director and LALD for "both sites" (two separate buildings located in town which had assisted living with dementia care license). On August 31, 2022, at 7:24 a.m. the Minnesota Board of Executives for Long-Term Services and	0 110		

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0 110	Continued From page 2 Support (BELTSS) website was checked for verification of assisted living director licensure for LALD-A. The website indicated no results found. On August 31, 2022, at 7:34 a.m. a representative of BELTSS informed via email LALD-A "missed a step updating Director of Record" and there were two locations listed. The representative of BELTSS informed LALD-A would need to receive a second license if LALD-A "oversees both locations" and LALD-A would "need to complete the shared license application" if LALD-A "does oversee both sites". At 10:00 a.m., the representative of BELTSS informed LALD-A had "one initial license, but did not indicate which facility LALD-A was using that license for, which is why there was no Director of Record listed under LALD-A's license. At 10:09 a.m., the representative of BELTSS informed LALD-A could "use the initial license at either location" and the license needed to be at the location LALD-A was using the license for. The representative of BELTSS informed LALD-A would "then need to complete the LALD Shared License application for the other location" and LALD-A would "receive a second license certificate for that building. [LALD-A] will need to go into her Director of Record found on [LALD-A's] license portal and indicate which facilities [LALD-A] is the LALD" of. On August 31, 2022, at 10:15 a.m. LALD-A stated the LALD license LALD-A had was for "both sites". LALD-A stated she had received an email from the representative of BELTSS regarding what needed to be completed for director of record and shared license application. No further information was provided.	0 110		

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0 110	Continued From page 3 TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;	0 250		

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0 250	Continued From page 4 (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 250		

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0 250	Continued From page 5 The findings include: During the entrance conference on August 29, 2022, at 12:23 p.m. licensed assisted living director (LALD)-A, director of nursing (DON)-B and registered nurse (RN)-C stated they were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities.	0 250		

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0 250	Continued From page 6 - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the	0 250		

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0 250	Continued From page 7 existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by owner (O)-N on May 24, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of June 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: -requirements in section 626.557, reporting of maltreatment of vulnerable adults; -training and competency evaluations of staff; -conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; -infection control practices; -conducting appropriate screenings, or	0 250		

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0 250	Continued From page 8 documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; -ensuring that nurses and licensed health professionals have current and valid licenses to practice; -medication and treatment management; -delegation of tasks by registered nurses or licensed health professionals; -supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued 0510, 0620, 0660, 1310, 1420, 1440, 1620, 1690, 1700, 1730, 1760, 1770, 1780, 1790, 1820, 1880, 1890, 1910, 1930, 1940, 1950, 1960, 1970, 2140, 3000, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and	0 470		

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0 470	Continued From page 9 (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the staffing plan was developed to determine staffing levels to meet the needs of all residents, and the 24-hour staffing schedule was posted with all required information. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	0 470		

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0 470	Continued From page 10 On August 29, 2022, at approximately 10:00 a.m. no posted staff schedule was observed in any area of the facility. At 12:23 p.m. during the entrance conference, licensed assisted living director (LALD)-A, director of nursing (DON)-B and registered nurse (RN)-C stated the daily staffing schedule was posted on the north and south "white boards." The staff that comes on shift "writes down their name and shift on" on the white boards for either the north or south side. At the time LALD-A, DON-B and RN-C stated shift hours and the number of staff scheduled was 6:00 a.m. to 2:30 p.m. with four staff (one person was cook) for the day shift, 2:00 p.m. to 10:30 p.m. with four staff (one person was cook) for the evening shift and 10:00 p.m. to 6:00 a.m. with two staff for the night shift. At 1:21 p.m., RN-C confirmed no staff names or shift hours were written on either the north or south side white boards. RN-C stated, "Yes" she had just written the staff names on the white boards. At the time the white board on the north side was observed to have written "staff [listed two staff first names]" and the south white board had written "Day shift [listed two staff first names]". The white boards were located by the north and south dining room/kitchen areas for residents to be able to view. On August 30, 2022, at 6:38 a.m. the white board on the north side was observed to have written "night shift [listed two staff first names]" and "Days [listed two staff first names]". At 6:42 a.m., the south white board had written "night shift [listed two staff first names]" and there were no written information of staff names or hours for the day shift. STAFFING SCHEDULE	0 470		

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0 470	Continued From page 11 The licensee lacked a posted daily staffing schedule developed by the clinical nurse supervisor to include: -direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; -direct-care staff member's resident assignments or work location; and -be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building STAFFING PLAN The licensee failed to develop and implement a staffing plan for determining its staffing level that: - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility On September 1, 2022, at 4:16 p.m. DON-B provided a Direct Care Staffing Plan dated April 19, 2022; however, the staffing plan indicated it was for another facility "[the licensee name] Minnesota Licensed Assisted Living Community" and indicated "we have the ability to service up to 85 residents" and indicated there were "first and second floors." The licensee lacked a staffing plan for the licensee's Assisted Living with Dementia Care license which could service up to 20 residents and was one level. At that time, LALD-A and DON-B confirmed the staffing plan referenced	0 470		

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0 470	Continued From page 12	0 470		

another facility name, the amount of residents the facility could service and addressed staffing for first and second floors. At 4:33 p.m., DON-B stated the Direct Care Staffing Plan dated April 19, 2022, was "for here," but she "didn't change the verbiage" for the name of the facility, the number of residents that could be serviced and floor levels. DON-B stated the "census and floors" was inaccurate, but the "staff amount was accurate" for what was needed for this license.

The staffing plan further indicated "when residents require a two-person assist there will be a minimum of two staff available at all times. Point Click Care is an electronic record system capable of looking at the acuity level at the site. This tool is used to help determine staffing. The staffing plan will be reviewed, at a minimum, two times per year." The Direct Care Staffing Plan did not address accurate name of the facility, level of floors the facility had, resident census numbers and did not indicate how many or if any residents required assist of two, what to do if multiple staff or others were out due to illness, and did not indicate when staffing levels would be adjusted.

The licensee's Staffing Policy and Procedure dated September 27, 2021, indicated the licensee would have an implemented, written staffing plan at each of their locations. A clinical nurse supervisor, or designee, would develop, write, and implement a staffing plan. The clinical nurse supervisor would develop a 24-hour daily staffing schedule. The 24-hour daily staffing schedule will include: Direct-care staff work schedules for each direct-care staff member; Indication of all work shifts, including days and hours worked; Identify direct-care staff member's resident assignments or work location. The daily work schedule would be posted at the beginning of each shift. The daily

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0 470	Continued From page 13 work schedule would be posted in a central location in each building of a facility or campus accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (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	0 480		

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0 480	Continued From page 14 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 August 30, 2022, for the specific Minnesota Food Code deficiencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=F	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;	0 485		

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0 485	Continued From page 15 (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, interview and record review, the licensee failed to ensure at least three nutritious meals daily according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines and failed to encourage residents' involvement in menu planning. This had the potential to affect all 17 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 29, 2022, at approximately 10:00 a.m. just inside of the entrance door a "week 3" menu was posted on a wall. At the time observation further revealed written on the north side white board was "lunch: philly hotdish, coleslaw, bread and butter, banana bars" and "supper cooks choice" and written on the south side white board "lunch: philly hotdish, coleslaw, bread and butter, banana bars" and "supper cooks choice, vegetable/fruit/milk". The white boards were located by the north and south dining room/kitchen areas for residents to be able to view.	0 485		

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0 485	Continued From page 16 On August 29, 2022, at 12:05 p.m. unlicensed personnel (ULP)-I was observed to serve the lunch meal to residents on the north side. Residents were served philly steak hotdish, coleslaw, bread/butter, banana bar desert and drinks. At the ULP-I stated, "Week two" was the menu being followed for meal service and showed surveyor the menu posted on the refrigerator in the north kitchen which indicated "Week 2" and listed for "noon" meal on "Monday 29th", "philly steak hotdish, creamy coleslaw, choice of fruit, milk, buttered bread, banana bars". The menu had an arrow drawn up to the handwritten word "hotdish" to replace philly steak "sandwich" and french fries had a line through. At 12:10 p.m. the same food (philly steak hotdish, coleslaw, bread/butter, banana bar desert) was taken on a cart to the south side kitchen to be served to residents. The licensee lacked to serve fruit for the lunch meal as indicated on the menu. The "week 2" menu identified the following foods were listed for meals: Sunday (28) Breakfast: choice of juice, choice of cereal, sausage links, cinnamon french toast, milk Noon: Mr. Rib, baked potato/margarine, carrots, roll/margarine, pie, milk Eve: egg bake, banana half, milk, peach desert Monday (29) Breakfast: choice of juice, choice of cereal, egg, toast, margarine/jelly, milk, breakfast burrito Noon: philly steak hotdish, creamy coleslaw, choice of fruit, milk, buttered bread, banana bars Eve: cooks choice, vegetable, fruit, milk and handwritten in was "pizza, cottage cheese with fruit, dessert left over in refrigerator pie, cherry bars, banana bars"	0 485		

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0 485	Continued From page 17 Tuesday (30) Breakfast: choice of juice, choice of cereal, milk, sausage, waffles Noon: chicken alfredo, broccoli, blueberry kuchen bar, milk, garlic stick, apple crisp Eve: cooks choice, pickled beets, mixed fruit and handwritten in was "brats/hotdogs, tator tot wedges, pickled beets, mixed fruit, milk" Wednesday (31) Breakfast: choice of juice, choice of cereal, milk, oatmeal Noon: classic meatloaf, mashed potatoes, beef gravy, vegetables, bread/margarine, caramel brownie, milk Eve: tomato soup, hot ham and cheese, pudding, jello with fruit, milk Thursday (1) Breakfast: choice of juice, choice of cereal, bacon, egg, toast, margarine/jelly, milk Noon: old fashioned tuna and noodles, seasonal vegetable, bread/margarine, milk, poke cake Eve: pizza burger, pickle, chips, oh henry bar, milk Friday (2) Breakfast: choice of juice, choice of cereal, scrambled egg, toast, margarine/jelly, milk Noon: sausage ring, mashed potatoes, German cucumber salad, bread/margarine, bread pudding, milk Eve: Italian wrap, potato chips, mandarin oranges, cookie, milk Saturday (3) Breakfast: choice of juice, choice of cereal, sausage link, french toast/syrup, milk Noon: chicken hotdish, buttered corn,	0 485		

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0 485	Continued From page 18 bread/margarine, summer yogurt pie, milk Eve: summer corn chowder, crackers, 1/2 deli sandwich, lettuce and tomato slice, applesauce, milk On September 1, 2022, at 10:36 a.m. licensed assisted living director (LALD)-A stated snacks were served two times daily to the residents. LALD-A verified snacks were not indicated on the menu and there were no other beverages listed on the menu besides milk. LALD-A reviewed the menu and confirmed the menu lacked to include fresh fruit and the menu did not consistently include the daily recommended dietary allowances to be served for vegetable and fruit according to the USDA guidelines. LALD-A stated the residents were "not involved" with menu planning, but "we will add that." The licensee's Menu Planning policy dated October 25, 2021, indicated Menus were planned and made available one week in advance in accordance with the minimum requirements of Minnesota Statute Chapter 144G, Assisted Living. Residents are given opportunities to participate in menu planning through the following: Interaction with dining service employees, Food Council meetings, Comment cards, Sharing food preferences during the admissions process and meals and snacks include seasonal fresh fruit and vegetables. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements	0 490		

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0 490	Continued From page 19 (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all of the licensee's current residents. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a	0 490		

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0 490	Continued From page 20	0 490		

resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

On August 29, 2022, at 12:23 p.m. during the entrance conference, licensed assisted living director (LALD)-A stated the licensee lost the staff person who was the activity assistant for resident daily activities. LALD-A stated the licensee planned a one time a week community activity, one time a week church service, staff interacted with residents with music, painting nails, games, taking outside, read paper, and when nursing students were in the facility they engaged with the residents.

During the survey from August 29, 2022, through September 1, 2022, daily programs of social and recreational activities were not observed to be conducted with residents by the unlicensed personnel in the common areas of the north and south wings.

Monthly calendars for activities were posted by the nurse office for the months of August 2022 and September 2022. The calendar for August 2022, included activities for ten days (church, pet therapy visit, music entertainment) and three days listed as "salon". The calendar for September included activities for nine days (church, pet therapy visit, music entertainment) and two days listed as "salon".

The licensee lacked a daily program of activities

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0 490	Continued From page 21 as required. The licensee's Description of Life Enrichment Programs and How Activities are Implemented In ALDC (assisted living with dementia care) policy dated October 25, 2021, indicated it was the licensee's policy to provide a selection of daily activities based on individual and group interests. Individual and group activities would be planned, as well as structured and nonstructured activities. Opportunities for outdoor time and for engagement with the broader community will be facilitated for those interested. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and	0 510		

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0 510	Continued From page 22	0 510		

maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for current recommendations for COVID-19. In addition, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to storage of medical equipment and handwashing during medication administration for one of two residents (R1) and during cares for two of two residents (R1, R2). This had the potential to affect all residents, staff and visitors.

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

POSTED SCREENING COVID-19
The licensee failed to post signage of restrictions for COVID-19 at facility entrances.

On August 29, 2022, at 10:00 a.m. upon entrance to the facility, there was no signage posted at the facility entrances for screening or restrictions for infection prevention and control for COVID-19.

On September 1, 2022, at 11:34 a.m. licensed assisted living director (LALD)-A and director of nursing (DON)-B stated regarding posted signage of restrictions for COVID-19 at the facility entrances, "we had something before, it must have gotten taken down."

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0 510	Continued From page 23 COVID-19 SCREENING VISITOR The licensee failed to screen a visitor upon entrance to the facility for COVID-19 symptoms and temperature. On September 1, 2022, at 9:15 a.m. an unknown visitor walked into the facility wearing a facial mask and did not screen self for COVID-19 before entering the facility. Maintenance (M)-L was present and did not intercede to inform the the unknown visitor of the need to screen for COVID-19 before entering the facility. The CDC guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated February 2, 2022, indicated ensure everyone is aware of recommended IPC practices in the facility. Post visual alert icons (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) with instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can help ensure people know that they reflect current recommendations. Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so that they can be properly managed: 1. a positive viral test for SARS-CoV-2; 2. symptoms of COVID-19; or 3. who meets criteria for quarantine or exclusion from work. Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.	0 510		

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0 510	Continued From page 24 STORAGE OF MEDICAL EQUIPMENT The licensee failed to store a resident's nebulizer equipment in the resident's room for sanitary purposes. On August 29, 2022, at 12:08 p.m. observation of the north staff desk identified an unknown resident's nebulizer equipment (multiple pieces) were taken apart and laid out on a paper towel on top of the desk. The desk was accessible to any person. On September 1, 2022, at 11:34 a.m. registered nurse (RN)-C stated staff were informed the nebulizer equipment should be stored in the resident room. HAND HYGIENE R1 The licensee failed to ensure handwashing during medication administration and personnel cares. On August 29, 2022, at 12:12 p.m. unlicensed personnel (ULP)-D applied gloves, administered one drop of eye medication into R1's eyes and removed gloves. ULP-D failed to wash hands before and after administration of R1's eye drop medication. On August 30, 2022, at 6:12 a.m. ULP-D was observed with gloves on to assist R1 with dressing (putting on socks, pants, shoes), removal of CPAP equipment, transfer from bed into wheelchair utilizing a platform and mechanical stand. ULP-D assisted to remove incontinent product and transfer R1 onto the toilet, handed a wet washcloth and dry towel to R1 for R1 to wash his own face. ULP-D provided R1 his eye glasses, made R1's bed and removed garbage from R1's room. ULP-D continued to	0 510		

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0 510	Continued From page 25 wear the same pair of gloves during all procedures. ULP-D exited R1's room with the same pair of gloves on and carried garbage out of R1's room to the the laundry room, removed gloves and washed hands. On August 30, 2022, at 8:28 a.m. ULP-D was observed to administer R1's medications. ULP-D failed to wash hands after administration of medications to R1. On September 1, 2022, at 11:46 a.m. DON-B stated gloves should be removed and hands washed after procedures where gloves become contaminated before touching anything else. DON-B further stated, "I'll have to do retraining using hand sanitizer or wash hands before and after each person." R2 The licensee failed to ensure hands were washed during the provision of cares and clean TED stockings (compression stockings used to prevent blood clots/reduce edema) were applied. On August 30, 2022, at approximately 6:20 a.m. ULP-E donned gloves, applied lotion to R2's lower extremities and then searched the room for R2's TED (thrombo embolic deterrent) stockings (compression socks used to increase circulation to prevent blood clots). ULP-E found a pair in R2's dirty laundry basket, stating "I cannot find other ones, I'll just use these." Using the same gloves, ULP-E assisted with putting TED stockings on both lower extremities. ULP-E went to the closet and asked R2 what she wished to wear for the day, pulled out the clothing and draped them over R2's walker. ULP-E then assisted R2 to a standing position, provided R2's standard walker and assisted with guiding R2 to the bathroom. R2 was assisted to sitting position	0 510		

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0 510	Continued From page 26	0 510		

on the toilet. R2's nasal cannula was removed and draped over the walker in front of R2. ULP-E got a clean washcloth, rinsed it with water and gave to R2 to independently wash her face. ULP-E rinsed wash cloth and applied soap to wet cloth, gave it to R2 as ULP-E assisted with removal of R2's pajama top. R2 washed areas on front side of her body. ULP-E washed R2's back and buttock area. Without removing gloves, ULP-E applied lotion to R2's back, then removed incontinence pad that was inside R2's underwear, applied a clean pad, and handed R2 a clean towel to dry herself with. ULP-E continued to use the same gloves while assisting R2 with dressing and with placing the nasal cannula to R2's nose area. ULP-E assisted R2 to a standing position with walker and directed R2 to comb hair and brush teeth. ULP-E removed gloves without washing her hands and proceeded to R2's sleeping area. ULP-E made the bed and tidied the room. R2 left the bathroom area and sat at her puzzle table. ULP-E offered to freshen R2's water, obtained clean water and offered a drink. ULP-E then used hand sanitizer as she left R2's room and before moving onto another resident.

On September 1, 2022, at approximately 6:30 p.m. RN-C stated her expectation was staff would wash their hands after removing gloves and using clean gloves when working from dirty to clean areas. RN-C also agreed that using dirty TED stockings was not appropriate.

The licensee's Procedure for Using Gloves policy dated September 17, 2021, indicated gloves were to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressings. Gloves would be removed carefully and disposed of in a

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0 510	Continued From page 27 proper container. Always remove gloves before working with clean areas. Rewash hands. The licensee's Nebulizers policy dated November 20, 2021, indicated after all medication has gone from the cup, turn off the machine. Remove the mouthpiece and medication cup from tubing. Wear gloves if touching the mouthpiece. Rinse the cup and mouthpiece with warm tap water. Let cup air dry on clean paper towel in resident's room. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information related to the grievance procedure. This had the potential to affect all residents, staff and visitors.	0 550		

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0 550	Continued From page 28 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked postings in a conspicuous location and a disclosure of resident advocacy to include: - a posting with all required content of the licensee's grievance procedure On September 1, 2022, at 9:29 a.m. observation with licensed assisted living director (LALD)-A identified by the front entrance door posted information of the name, telephone number, and e-mail contact information of the individual responsible for handling resident grievances and contact information for the state and applicable regional Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. However, the posting lacked information regarding the licensee's grievance procedure. LALD-A confirmed the posted information lacked the licensee's grievance procedure. LALD-A stated the licensee's grievance procedure was in the resident "contract." No further information was provided.	0 550		

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0 550	Continued From page 29 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 620 SS=H	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected abuse; failed to notify emergency contact of resident to resident sexual abuse and failed to complete a thorough investigation for occurrences of suspected abuse for five of five residents (R14, R15, R6, R17, R16). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	0 620		

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0 620	Continued From page 30 The findings include: R14/R15 R14's diagnoses included dementia (memory loss) likely multifactorial in etiology with resulting behavioral disturbance. R14's MAARC report submitted Friday, February 11, 2022, at 12:47 p.m., indicated "Description of Incident", on February 10, 2022, at 7:30 a.m. staff reported resident was found in the dining area with only his underwear on. R14 had pulled out his penis and was holding it in his hand and waving in a female peer's face (R15). R14 was saying "come on baby touch it." Resident (R15) was upset and telling R14 "no, get away." Staff intervened and took R14 back to room and assisted getting R14 dressed. R14's service plan initiated February 10, 2022, indicated sexually inappropriate behavior. Responds to redirection. Staff will monitor resident throughout the day and night. Doors to resident's room will be locked by 8 pm. A door alarm was be added to resident's room, so staff are aware when R14 comes out. R15's diagnoses included Alzheimer's disease (memory loss) and anxiety. R15's MAARC report submitted Thursday, February 17, 2022, at 13:24 (1:24 p.m.) indicated "Description of Incident", on February 10, 2022, at 7:30 a.m. the same information as above on R14's MAARC report, and indicated R15 remains very scared of R14. R14 was sent to the emergency room (ER) and the provider note stated if R14 "gets another erection, put [R14] in a cool shower, if [R14] continues to be inappropriate, put [R14] on a one (1) to one (1)	0 620		

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0 620	Continued From page 31 with sitter. We are not staffed to offer that and the facility does not offer that. The bedroom doors are shut by 8 p.m. Door sensor was placed on [R14's] door." On August 31, 2022, at 11:56 a.m. registered nurse (RN)-C verified the time the incident was reported. RN-C stated she had talked to R15, and R15 "was ok" and she had talked to R14, but R14 "denied it all." RN-C stated family was notified and staff were informed of new behavior interventions. RN-C stated there was no documentation of staff interviews conducted beyond information documented in the MAARC report to determine if any other resident to resident sexual abuse incidents had occurred. RN-C stated she had not interviewed other residents to determine if other resident to resident sexual abuse had occurred. R6/R14 R6's diagnoses included Alzheimer's disease (memory loss). A MAARC report submitted Monday, April 4, 2022, at 11:18 a.m. indicated "Description of Incident," on April 1, 2022, at 5:00 p.m. R14's door alarm went off and R14 had come out of his room and was wandering the facility. At 8:00 p.m. unlicensed personnel (ULP)-M had seen R14 come out of R6's room. At 9:00 p.m. ULP-H was giving R6 a shower and had inquired to R6 "if there was a man in her room earlier." R6 stated, "Yes, he was trying to get fresh with me. He was trying to get me to play with his penis, but I said NO and then he was trying to insert it into me." R6 stated R14 "told her it would make her feel better."	0 620		

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0 620	Continued From page 32 A MAARC report submitted Friday, May 27, 2022, at 12:50 p.m. indicated "Description of Incident", on May 26, 2022, at 3:45 p.m. R14 was seen by staff to be coming out of R6's room. R16 reported to staff "oh he just likes to massage my breasts, that's all." On August 31, 2022, at 11:56 a.m. RN-C stated the resident to resident sexual abuse incident which occurred on April 1, 2022, was not reported until April 4, 2022, due to "weekend staff didn't think it was important." RN-C stated, "Some education on that, reporting immediately" was done with staff. RN-C stated if she had known about it right away, she would have "called police and had a test kit, rape kit done, but they [staff] didn't report until Monday." RN-C stated, "I usually report right away as soon as I know about it." RN-C stated staff were educated regarding what need to be reported, but there was no documentation of the education provided. RN-C stated she had talked to R6 and R14 and the interview should be in the resident records. RN-C stated staff interviews were not conducted beyond information documented in the MAARC reports and resident records to determine if other resident to resident sexual abuse had occurred. RN-C stated no other residents were interviewed to determine if other resident to resident sexual abuse had occurred. At that time, licensed assisted living director (LALD)-A and director of nursing (DON)-B stated, "No" the licensee had not notified R6's family regarding the resident to resident sexual contact. LALD-A and DON-B stated the Ombudsman had informed "not to tell [R6's] family." LALD-A and DON-B stated the Ombudsman had stated "this is to be expected in memory care. Very common behavior in memory care" and "notifying [R6's] family would be a violation of privacy for [R14]."	0 620		

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0 620	Continued From page 33 The licensee failed to immediately report a resident to resident sexual abuse incident to MARRC, failed to inform R6's emergency contact person #1 (family member) of resident to resident sexual abuse incidents involving R6, and lacked evidence of a thorough investigation of the incident. R17 R17's diagnoses included dementia (memory loss). R17's service plan initiated April 28, 2022, indicated no known injuries, no pain reported, needs occasional supervision/standby help and supervision to walk, uses walker for mobility and resident will have a chair alarm as she sleeps in a recliner. A Facility Bulletin (posted on the facility computer system) indicated R17 had moved in this afternoon, has "had a lot of falls, so for now please do an assist of one with transfers. She is supposed to be able to walk independent but needs her walker at all times. She sleeps in a recliner. She has two chair sensors as she sleeps in her recliner. Let's just do an assist of one for now please until we get some more info [information]." A MAARC report submitted Monday, May 2, 2022, at 13:33 (1:33 p.m.), indicated "Description of Incident," on April 30, 2022, when R17's family came to the facility resident was lethargic and unable to sip from a straw or respond to conversation. There were no reports of fall or resident complaining of pain throughout the night. When staff tried to get resident up in the morning, she required a lift to get up and into chair. "Family	0 620		

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0 620	Continued From page 34 took resident to hospital via ambulance." Writer was notified today that resident has a broken right hip requiring surgery. The report further indicated resident was admitted to the facility on "April 28th" at 4:00 p.m. due to many falls. Resident had four falls from April 21 to April 24. Resident had a large bruise on right hip upon admission. Family had taken resident to a doctor appointment on Friday (April 29) where it was found that R17 had a urinary tract infection (UTI). On August 31, 2022, at 11:56 a.m. LALD-A stated there was no facility incident report for the above incident. RN-C stated she was informed R17 was taken to the hospital over the weekend but did not know R17 had a fractured hip until Monday morning when the family informed her. RN-C stated she had not interviewed R17's family to inquire if R17 had any incidents when R17's family had taken R17 to the doctor appointment on Friday, April 29, 2022. RN-C stated she had no documentation of staff interviews since R17 was admitted determining if abuse/neglect occurred related to the diagnosis of right hip fracture. RN-C stated she had asked staff if R17 "had fallen or if they had noticed anything strange" with R17. Staff reported R17 was "tired" and was "sleeping in chair". RN-C stated she had not documented the information. RN-C stated R17 walked independent upon admission and had no complaints of pain. The licensee lacked documented evidence of employee interviews since admission due to the diagnosis of right hip fracture two days after admission to determine if abuse/neglect occurred. R16 R16's diagnoses included dementia (memory	0 620		

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0 620	Continued From page 35	0 620		

loss) without behavioral disturbance, diabetes (condition that affects the way the body processes blood sugar) and age related osteoporosis (condition in which bones become weak and brittle) without current pathological fracture.

R16's Progress note dated August 14, 2022, indicated RN-F had "received phone call from facility" resident had fallen and family had questions about resident's return.

A MAARC report submitted Monday, August 15, 2022, at 11:47 a.m., indicated "Description of Incident", on the evening of August 13, 2022, staff heard a noise and resident began to yell. Staff found resident on the floor. "Resident stated she was reaching for something on her couch. Resident has dementia so she did not give much more of an explanation." Staff called for assistance from emergency medical service (EMS). When EMS arrived resident began complaining of right hip pain. Resident was taken to hospital where it was determined resident had a broken right hip. Resident had surgery on August 14, 2022, to repair right hip. Action taken indicated resident chair alarm is in place for when resident returns as well as a bed alarm.

The licensee failed to immediately report to MAARC of an unwitnessed fall with injury (right hip fracture) and lacked evidence of a thorough investigation to determine if abuse/neglect occurred.

On August 31, 2022, at 11:56 a.m. RN-C stated the reason for delay of reporting was the incident occurred on a Saturday and she had not reported until on Monday. RN-C verified there was no evidence of a thorough investigation to determine

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0 620	Continued From page 36 if abuse/neglect occurred. The licensee's Vulnerable Adult Maltreatment Policy dated October 11, 2021, indicated for reporting maltreatment any staff person who witnesses or suspects maltreatment of a vulnerable adult (VA) would immediately report the incident to their assisted living director and that person would complete an incident report. If the incident appears to be suspected abuse, neglect, or financial exploitation, assisted living director/regional nurse would immediately make a report to the CEP (common entry point). MAARC website was indicated on the policy. "Immediately" means as soon as possible, but no longer than 24 hours from the time the assisted living director/registered nurse received initial knowledge that the incident occurred. If it appears at any time a crime may have been committed , assisted living director/regional nurse would immediately contact the police if the witness had not already done so. Internal Investigation: staff would complete an incident report. The DNS, LALD, or designee would complete an internal investigation pertaining to the report of potential or suspected maltreatment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:	0 640		

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0 640	Continued From page 37 (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all 17 residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 1, 2022, at 9:23 a.m. during observation of the facility, a facility phone was located on the north and south side staff desks. There was no posted 911 emergency number and the required MAARC information posted in	0 640		

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0 640	Continued From page 38 common areas or near the telephone. At 9:25 a.m., unlicensed personnel (ULP)-J stated the phones located on the the north and south side staff desks were for resident use. On September 1, 2022, at 9:30 a.m. licensed assisted living director (LALD)-A observed the areas above with the surveyor and confirmed the 911 emergency number and the required MAARC information was not posted in common areas and near telephones. LALD-A stated she was "not aware" of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	0 660		

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0 660	Continued From page 39 by: Based on interview and record review, the licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's TB facility risk assessment dated February 11, 2022, indicated the licensee was a low risk. The licensee lacked a written TB infection control plan for the procedures to address early recognition and referral for handling residents with suspected or confirmed active TB; therefore, none of the licensee's employees had received training on their role in the procedure. The licensee's Transmission Based Precautions policy dated September 21, 2021, indicated "1. Transmission-based precautions will be initiated when there is reason to believe that a resident has an infectious or communicable disease. Please refer to ICP 15.0 Quick Reference Guide designed by the CDC to determine if Isolation precautions may be warranted. CDC	0 660		

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	28411	A. BUILDING: _____ B. WING _____	09/01/2022

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0 660	Continued From page 40 Transmission Precautions 2. Resident Placement: TB: please see TB management policy. ICP 11.0. If the disease can be managed within the facility, place the resident in a private room, if possible. When a private room is not available, place residents together, with the same infection and the same microorganism if appropriate and if able. If a private room is not available and residents with like infections cannot be grouped, the RN will determine an appropriate plan and seek physician input as needed." The licensee's TB Prevention and Control Document No.: ICP 11.0 policy dated September 20, 2021, indicated "h. If a case of suspected or confirmed TB disease is identified among staff or clients, we assure that appropriate actions will be taken immediately which may include assistance with arrangement for transfer of the client to an inpatient facility while collaborating and cooperating with local public health and MDH." The 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 the following: written TB infection control procedures. Procedures should address: Early recognition: All health care workers should know the signs and symptoms of TB and their role in their facility's TB infection control program. Isolation: Place a potentially infectious TB patient in an airborne infection isolation (AII) room if available; If not, place patient in separate room with door shut. Referral: If your setting does not handle TB patients, transfer potentially infections TB patients to a setting that is equipped to evaluate and treat TB patients. TB training is required at time of hire for all health care workers and the content should	0 660		

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0 660	Continued From page 41 focus on basic information: Your health care setting's infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing. On September 1, 2022, at 11:23 a.m. director of nursing (DON)-B stated, "What is in policy is what we have" regarding the licensee's TB infection control plan for the procedures to address early recognition and referral for handling residents with suspected or confirmed active TB. The licensee's TB Prevention and Control Document No.: ICP 11.0 policy dated September 20, 2021, indicated the RN was responsible for establishing and maintaining the TB prevention and control program. Responsibilities included education of staff regarding TB signs and symptoms, the licensee's infection control plan and other communicable diseases and would be assigned annually though Educare modules. 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 (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	0 680		

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0 680	Continued From page 42 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 observation, interview and record review, the licensee failed to develop an all-hazards emergency preparedness (EP) program and plan to include Appendix Z required elements. This had the potential to affect all 17 residents in the facility, staff and any visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 680		

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0 680	Continued From page 43 The licensee lacked required information according to Emergency Preparedness: Appendix Z. On September 1, 2022, at 12:52 p.m. director of nursing (DON)-B was interviewed regarding the licensee's Emergency Preparedness Plan. DON-B confirmed the licensee's Emergency Preparedness Plan lacked the following: - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure addressing use of volunteers, including the process/role for integration; - policy and procedures addressing development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - communication plan which includes its ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee; and - communication plan which includes method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives The licensee's Emergency Response Policy and Procedure dated January 25, 2022, Subject: Disaster Plan, indicated the policy was to set forth basic responsibilities and outline actions to be taken to protect life, provide resident care and protect property in [the licensee] during natural disasters or man-made situations. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680		

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0 680	Continued From page 44 (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been	0 730		

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0 730	Continued From page 45 provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's record lacked a discharge summary to include: - diagnoses; - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the	0 730		

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0 730	Continued From page 46 latest assessment or review including baseline and current mental, behavioral, and functional status. R5 began receiving services on September 23, 2019, and was discharged on April 2, 2022. R5's Progress Note dated March 28, 2022, indicated R5's family member had called this writer to give update on resident's condition. Residents right hip is fractured and is inoperable. Family is looking for a skilled nursing home for resident. Family member will keep this writer up to date on placement. On September 1, 2022, at 11:50 a.m. registered nurse (RN)-C stated R5 was discharged on April 2, 2022. RN-C stated, "I didn't put a note in" referring to R2's progress notes. RN-C stated the discharge summary would have been documented in R2's progress notes if she had documented a discharge summary. The licensee's Discharge Summary policy dated October 11, 2021, indicated a discharge summary would be written by the time of discharge. The discharge summary would include, if applicable, "a. Summary of the resident's stay, including i. Diagnosis ii. Courses of illnesses iii. Allergies iv. Treatments v. Therapies vi. Pertinent lab results vii. Pertinent radiology results viii. Pertinent consultation results ix. Final summary of the resident's status. The summary will be based upon the latest assessment or review and, if applicable, will include resident status including baseline and current mental, behavioral, and functional status." No further information was provided.	0 730		

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0 730	Continued From page 47 TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
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.	0 810		

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0 810	Continued From page 48 This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct the required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on September 1, 2022, at approximately 10:45 a.m. with Licensed Assisted Living Director (LALD)-A and Maintenance (M)-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 fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, M-L indicated that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan	0 810		

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0 810	Continued From page 49 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, M-L indicated 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, LALD-A and M-L could not verify the training frequency for employees. A policy on employee training was requested but was not able to be provided. 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-A stated that the licensee has not offered training to residents on fire safety and evacuation due to being a memory care facility and that it would be ineffective. A policy on resident training for fire safety and evacuation but requested one was not able to be provided. Record review of the available documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. Provided documentation indicated that only fire drills were conducted and had no provisions for evacuation procedures included. During interview, LALD-A verified that only fire drills were conducted and felt that evacuation was not a reasonable response for memory care facility that was fully sprinkled.	0 810		

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0 810	Continued From page 50 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee's contract included a disclosure of the category of assisted living facility license held by the facility for two for two residents (R1, R2) with records reviewed.	0 920		

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0 920	Continued From page 51 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: The licensee had an assisted living with dementia care license effective August 1, 2022. R1's Resident Agreement Assisted Living with Dementia Care was signed July 26, 2022, by licensed assisted living director (LALD)-A and was signed by R1's resident/responsible party on August 26, 2022. R2's Resident Agreement Assisted Living with Dementia Care was signed by LALD-A on August 11, 2022, and was signed by R2's resident/responsible party on August 13, 2022. The contracts identified "2. Important Contact Information" and indicated in an area below "Assisted Living Licensee: Health Facility ID: 28411". The licensee's Resident Agreement Assisted Living with Dementia Care being provided to all residents lacked accurate disclosure of the category of assisted living facility license held by the facility. On September 1, 2022, at approximately 5:10 p.m. LALD-A confirmed the contract being provided to all residents of the facility did not	0 920		

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0 920	Continued From page 52 disclose the category of assisted living facility license held by the facility, which was an assisted living with dementia care license. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 950 SS=C	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	0 950		

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0 950	Continued From page 53 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 ensure the licensee provided the required notice for right to designated representative on a document separate from the contract for two for two residents (R1, R2) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Resident Agreement Assisted Living with Dementia Care was signed July 26, 2022, by licensed assisted living director (LALD)-A and was signed by R1's resident/responsible party on August 26, 2022. The first page of the agreement contained the required space for the name and contact information of the designated representative and a box the resident would initial if the resident declined to name a designated representative. R2 R2's Resident Agreement Assisted Living with Dementia Care was signed by LALD-A on August 11, 2022, and was signed by R2's resident/responsible party on August 13, 2022. The first page of the agreement contained the required space for the name and contact	0 950		

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0 950	Continued From page 54 information of the designated representative and a box the resident would initial if the resident declined to name a designated representative. However, R1 and R2's records lacked evidence in writing of providing on a document separate from the contact verbatim notice of "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." On September 1, 2022, at approximately 5:10 p.m. LALD-A stated, "No" she had not provided the required above notice to residents on a document separate from the contract as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01310 SS=F	144G.60 Subd. 3 Licensed health professionals and nurses (a) Licensed health professionals and nurses providing services as employees of a licensed facility must possess a current Minnesota license or registration to practice. (b) Licensed health professionals and registered nurses must be competent in assessing resident	01310		

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needs, planning appropriate services to meet resident needs, implementing services, and supervising staff if assigned.
(c) Nothing in this section limits or expands the rights of nurses or licensed health professionals to provide services within the scope of their licenses or registrations, as provided by law.

This MN Requirement is not met as evidenced by:
Based on interview and record review the licensee failed to ensure one of four registered nurse (RN-F) who was providing services as an employee of the licensed facility had a current Minnesota license or registration to practice which had the potential to affect all residents and staff.

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

The findings include:

During the entrance conference on August 29, 2022, at 12:23 p.m., licensed assisted living director (LALD)-A, director of nursing (DON)-B and registered nurse (RN)-C were present. DON-B stated there was a total of four RNs who were employed by the licensee. A request was made to provide current licensure for the four RNs.

On August 29, 202, at 1:53 p.m. review of RN-F's Minnesota (MN) Board of Nursing search for

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licensure sheet printed and provided by the licensee from the MN Board of Nursing website, indicated license type "Registered Nurse Expire Date 6/30/2022". At 2:07 p.m., DON-B was shown the Minnesota Board of Nursing search for licensure sheet for RN-F which was provided to surveyor. DON-B stated she was "not aware" RN-F's license was expired. DON-B called RN-F via phone. DON-B stated RN-F informed she had "renewed her RN license a day late on July 1, 2022." At that time, DON-B viewed the MN Board of Nursing website and confirmed RN-F's current status for RN license read "Expired" and the expiration date was June 30, 2022. DON-B had verbally instructed RN-F she would need to call the MN Board of Nursing regarding the current status of her RN license being expired. DON-B provided a printed out email from RN-F showing RN-F had made an electronic payment for renewal of her RN licensure on July 1, 2022. Licensed assisted living director (LALD)-A was also present and stated she was "not aware" RN-F's RN license for MN was expired. At 2:19 p.m., LALD-A stated for the days RN-F was on call for the months of July and August 2022, RN-F would have been "on call 24 hours a day" to respond as the nurse on call. At 2:35 p.m., DON-B stated when nurses were on call "if needed they would come in to the building" and the nurse "gave direction over the phone" to staff regarding resident care. LALD-A provided printed out Timesheet Edit reports which identified RN-F was on call for the dates of July 2, 3, 9, 10, 23, 24, 2022 and August 13 and 14, 2022.

R16's Progress Note dated August 14, 2022, documented by RN-F, indicated RN-F was notified by a staff person regarding R16 had fallen and was sent to the hospital.

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01310	Continued From page 57 The licensee's Supervision of Licensed and Unlicensed Personnel policy dated October 13, 2021, indicated for "Supervision of Licensed Staff: The Clinical Nurse Supervisor is responsible for supervision of licensed staff." The policy did not address ensuring current licensure for licensed staff. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01310		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. 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) had documented instructions for a delegated task in the resident's	01420		

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record and ensured prior to the delegation the unlicensed personnel (ULP-D, ULP-E) was trained in the proper methods and was able to demonstrate the ability to follow the procedures for one of one resident (R1).

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

R1's Service Plan was signed by licensed assisted living director (LALD)-A on April 27, 2022, and was signed by R1's resident/responsible party on June 21, 2022, indicated R1 needs help to sit up. Staff will put the head of the bed up and swing resident's legs off the bed while he helps to pull himself up with an easy stand. The service plan did not include R1 utilized a platform stand.

On August 30, 2022, at 6:12 a.m. ULP-D was observed to place a white platform stand beside R1's bed, directed R1 to stand up on the platform, and then from the platform step down and place feet onto the base of a mechanical stand and hold onto the handles of the mechanical stand with both hands. ULP-D then placed two turnable pads on the mechanical stand underneath R1's buttocks and pushed R1 in a standing position on the mechanical stand into the bathroom, removed R1 incontinent product and assisted R1 to sit down onto the toilet.

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01420	Continued From page 59 R1's 90 day assessment dated August 2, 2022, indicated for bed mobility needs help to sit up. Staff will put the head of the bed up and swing residents' legs off the bed while he helps to pull himself up with easy stand. The assessment did not include R1 utilizing a platform stand. R1's record lacked assessment for safe use of the platform stand and mechanical stand by the RN and documented instructions for the utilization of the platform stand and mechanical stand. ULP-D had a hire date of December 19, 2011. ULP-E had a hire date of June 27, 2022. ULP-D and ULP-E's record lacked training and skills demonstration for the delegated task of the platform stand and mechanical stand being utilized for R1. On September 1, 2022, at 3:57 p.m. RN-C stated she had gone over the use of the platform stand and mechanical stand utilized for R1 with the staff. RN-B confirmed there were documented instructions for the utilization of the platform stand and mechanical stand. RN-C verified ULP-D and ULP-E's records lacked evidence of training and competency for utilization of the platform stand and mechanical stand with R1. The licensee's Delegation of Nursing Tasks/Treatments policy dated October 29, 2021, indicated the RN would complete an assessment of the resident and determine need for nursing services. The RN would develop a service plan for providing the services according to the resident's needs and preferences. Verify the ULP was trained and competent and was instructed in	01420		

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01420	Continued From page 60 the proper methods to perform the task with respect to the specific resident; if the ULP was not trained, the RN would provide training in-person, verbally, or through other acceptable methods. The RN or other appropriately licensed staff would document any ULP training and/or competencies. When needed, the RN would provide written instructions for performing the procedure to the ULP. The RN would provide supervision appropriate for the task. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01440 SS=D	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 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	01440		

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01440	Continued From page 61 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 interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the facility for one of two unlicensed personnel (ULP-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E's employee record lacked documentation of a registered nurse (RN) supervising ULP-E performing delegated tasks. ULP-E was hired on June 27, 2022, to provide direct care services to residents at the assisted living. ULP-E's record indicated ULP-E was trained for medications and treatments on July 2, 6, 8 and 10, 2022, through Educare (computer training program) and competency evaluated for TED stockings (used to reduce swelling and prevent blood clots), oxygen (used for breathing),	01440		

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01440	Continued From page 62 nebulizer medication administration (used to help breathing), continuous positive airway pressure (CPAP) (used to help breathing when sleeping), blood glucose testing (checking level of sugar in blood), ace wraps (used to reduce swelling) on July 12, 2022. On September 1, 2022, at 3:57 p.m. registered nurse (RN)-C stated, "No, not done yet" regarding ULP-E having direct supervision of performing delegated tasks within 30 calendar days as required by the RN. The licensee's Supervision of licensed and unlicensed Personnel policy dated October 13, 2021, indicated an RN would supervise staff who perform delegated nursing, treatment, or therapy services. Supervision of ULP by an RN would be direct supervision of the staff performing a delegated task(s) within 30 calendar days after the staff member begins working and first performs the delegated resident tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	01620		

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01620	Continued From page 63 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) had completed and/or documented a comprehensive assessment for change in condition for one of one resident (R4) related to falls and failed to ensure the RN completed comprehensive reassessment for two of two residents (R1, R2). 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:	01620		

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01620	Continued From page 64 R4 R4's record lacked evidence the RN had conducted comprehensive assessment of the resident for a change in condition related to falls, including implementation of interventions from review of causative factors to minimize the risk for future falls and potential injury. R4's diagnoses included frontotemporal dementia, depression, muscle weakness and history of falling. R4's Service Plan signed by licensed assisted living director (LALD)-A on April 27, 2022, and R4's resident/responsible party on June 21, 2022, indicated R4 received services including mobility (needs supervision to ensure safety when transferring-unsteadiness-needs help with transfer-one person assist, needs occasional supervision/standby help and supervision to walk-needs full help to walk-depends on staff for routine escorts-uses assistive walking devices-walker), toileting (needs reminders/help to use bathroom through the day and night, needs help with peri-care, bladder incontinence), dressing (needs full help to dress and undress), hygiene/grooming (needs full help with grooming/hygiene), bathing (needs full help with bathing/showering), manage environment (needs help reducing fall risk by removing clutter in apartment). R4's 90-day assessment (comprehensive) was dated July 6, 2022. The assessment indicated for service packages area "suggested tasks for documentation" the areas of ADLs complete assistance, bladder incontinence, bowel incontinence, dressing, reorientation/cueing were marked and other tasks marked for documenting	01620		

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included behavioral interventions frequent. Gait/Balance (balance problem while standing/waling, stand by assist), constant or frequent pacing or wandering, disorientated daily, mental status (confused/anxious/agitated or resistive, resident becomes upset when family member is not able to visit. Searches the doors to see if can get out, will bang on doors and become agitated. Staff will redirect with food, snacks, attempting to find a western or sports on TV or another activity. If resident is not redirectable staff will give PRN (as needed) as ordered by the provider), physical therapy (currently being seen three times a week from home health agency), mobility aids (wheeled walker), manage environment (needs help reducing fall risk by removing clutter in apartment). Injuries (does not appear to have any injuries at this time. Does like to wander and has a tab alarm on at all times. Interventions in place are: tab alarm, bed alarm. Staff are instructed to walk with resident and his walker when he gets anxious. Staff will attempt to distract with coffee, food, or a Twins game when they are playing. Resident likes sports of any kind but does not always stay in one place to watch it. Staff will offer a phone call to resident's family member. If all this fails, resident has a PRN that can be given. Resident should be kept in sight when at all possible). Fall history (has fallen in the last six months, 10 or more, date of last fall was June 29, 2022).

R4's record included the following Incident Reports (IR) documented by unlicensed personnel (ULP) and Progress Notes (PN) documented by registered nurse (RN)-C:

-IR dated March 10, 2022, 8:35 a.m. witnessed fall, staff was walking in the dining room and seen out of the corner of eye resident falling sideways.

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01620	Continued From page 66 No injuries. Immediate action taken: both staff and RN assisted resident up after RN did check. -PN dated March 10, 2022, 12:19 p.m. (witnessed fall March 10, 2022) indicated fell while getting up from breakfast table. Resident stated he caught foot on the leg of the chair and tripped landing on left side. Did not hit head. No bruising or abrasions noted. -IR dated March 13, 2022, found on living room floor near fireplace about 6:45 p.m. There was a chair tipped over near him. Staff called more staff to come to south side and assist. Resident found to have skin tear on his right elbow. Immediate Action: lift assist was called as the fall was not witnessed. Skin tear on right elbow. Staff attempted to stop bleeding with a towel and waited for lift assist. -PN dated March 14, 2022, at 10:51 a.m. (un-witnessed fall March 13, 2022) indicated resident was assessed at ER (emergency room). No other injuries were found. Skin tear was bandaged. Writer cleaned and redressed wound on the resident's elbow. Staff will monitor for infection and notify nurse with concerns. -IR dated March 14, 2022, 4:40 a.m. found on floor in bedroom between chair and bed. Gash on left side wrist. Mark on left side forehead. Immediate Action:two staff assisted getting off the ground. -PN dated March 14, 2022, 11:07 a.m. (witnessed fall March 14, 2022) indicated apparently slid out of bed this morning causing abrasion on left side wrist. Resident has been unsteady on his feet and is encouraged to ask for help, but is impulsive and tries to ambulate and transfer alone. Staff will encourage resident to ask for help when attempting to ambulate or transfer.	01620		

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	28411	A. BUILDING: _____ B. WING _____	09/01/2022

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01620	Continued From page 67 -IR dated March 26, 2022, 4:40 a.m. found lying on floor in South Wing Laundry room. Immediate Action: called on-call nurse. Two person assist into wheelchair and observed for any abnormalities. Did not observe any cuts or abrasions due to fall. -PN dated March 28, 2022, 11:35 a.m. (un-witnessed fall March 26, 2022) indicated resident appears to have no injury from his fall. Staff were educated to have personal alarm on and have resident in an area where he is easily seen when not in bed. -IR dated April 10, 2022, 11:25 a.m. "staff came out and noticed that resident was on the floor in the dining room by the table and chair. When sitting staff up to get transfer belt around resident, staff noticed blood on the floor. Staff seen a skin tear on right arm on the backside about the elbow. Two person assist to get up off of the floor in dining room. Resident Description: Resident was self-walking and was trying to sit in the chair by the table. resident missed the chair and was on the floor." -PN dated April 13, 2022, 9:39 a.m. (un-witnessed fall April 10, 2022) indicated residents skin tear above right elbow was cleaned, and a bandage was applied. It is scabbed over and shows no signs of infection. Staff will monitor for infection and notify nursing with concerns -IR dated April 14, 2022, 2:22 p.m. indicated incident location: activity room. This was an unwitnessed fall. Immediate Action: this writer got the nurse and other staff to two assist with a gait belt, into his wheelchair. Resident was looked over by RN -PN dated April 14, 2022, 2:43 p.m. (un-witnessed fall April 14, 2022) indicated	01620		

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01620	Continued From page 68	01620		

according to resident, he was attempting to walk without assistance. He stood up from the chair and lost his balance. Resident denied any pain or injury. No bruising or abrasions were noted.

-IR dated April 17, 2022, 10:50 a.m. indicated staff found him on the floor in the dining room. He was walking with his walker it was tipped over beside him. Resident Description: Resident unable to give description. Immediate Action: staff asked if anything hurts checked him from head to toe.
-PN dated April 18, 2022, 12:49 p.m. (un-witnessed fall April 17, 2022) indicated resident denies any pain or injury. No noted bruising or abrasions at this time.

-IR dated May 9, 2022, 4:06 p.m. indicated resident was sitting in common area, he attempted to get up on his own and fell. Immediate Action: this writer and nurse came to aid of resident when we heard incident.
-PN dated May 10, 2022, 3:05 p.m. (un-witnessed fall May 9, 2022) indicated resident appears to be ok except for a skin tear on his right wrist. Area was cleaned and bandage was applied. No other injuries noted at this time.

-IR dated May 11, 2022, 7:38 p.m. indicated resident was outside by self, fell on concrete, resident was laying on his left side when staff seen resident, resident was trying to get up off the ground. Resident Description: Resident was laying on his left side, bleeding from left arm. Resident was trying to pull himself up off the ground, resident was alert. Immediate Action: nurse notified right away, resident was helpful to get off the ground, two people and gait belt. Band aid where resident was bleeding.
-PN dated May 16, 2022, 10:08 a.m.

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01620	Continued From page 69 (un-witnessed fall May 11, 2022) indicated resident does not appear to be injured other than the right elbow tear. He is getting around normally, and no other bruising or lacerations noted. Resident has a personal alarm on at all times. Bed alarm in his room. Staff will keep resident within sight as much as possible. Staff will continue to remind resident that he needs help to transfer and needs to let staff know he would like to get up. Staff will monitor and let nursing know of any concerns. -IR dated May 14, 2022, 11:20 a.m. indicated R4 was put in recliner half hour before fall. He had attempted to self-transfer to his wheelchair. Has been noticed wheelchair brakes are very hard to place in brake mode. On attempt to self-transfer, resident was trying to get to wheelchair next to his recliner and ended up on the floor after falling backwards and laying on his right side. Shortly after falling, nurse aides were nearby to assess him and called for assistance to get him up and off the floor. Claims to not have any pain but is seen to be a bit cold to the touch and excess sweat is present on face. BP [blood pressure] 160/60 Pulse 78 O2 [oxygen saturation]: 97 Temp: 97.7. Resident Description: As stated resident claimed to have been trying to self-transfer, forgetting the need to ask for assistance when doing so. Was trying to get into his wheelchair and ended up falling backwards and feet went up. Resident claims to not have any pain. Says he is okay and feeling like he normally does on a normal day. Immediate Action: As noted in his care plan action, paramedics were notified and showed up shortly after being called. They had helped with the need of lifting and transferring him back into his wheelchair from falling on the floor. BP was taken again and was stated to be normal as well as his blood sugar	01620		

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01620	Continued From page 70 levels being normal. -PN dated May 16, 2022, 10:05 a.m. (un-witnessed fall May 14, 2022) lacked any documented information (was blank). -IR dated May 17, 2022, 2:13 p.m. documented by RN-C, indicated staff was working on north side of building and heard tab alarm go off. Staff traced noise to the south side of the building where R4 was found on living room floor. R4 was responsive and appeared to have no injury. R4 denied having any pain, staff let him know to stay still and wait for assistance to get up. Staff then called lift assist and waited for them to arrive. Resident Description: Resident unsure of what happened just kept saying that he fell. Immediate Action: On call nurse was notified and lift assist determined he was not injured, and they assisted to get him up. -PN dated May 17, 2022, 2:13 p.m. (un-witnessed fall May 17, 2022) indicated resident does not appear to be injured. He is getting around normally, and no other bruising or lacerations noted. Resident has a personal alarm on at all times. Bed alarm in his room. Staff will keep resident within sight as much as possible. Staff will continue to remind resident that he needs help to transfer and needs to let staff know he would like to get up. Staff will monitor and let nursing know of any concerns. -IR dated May 20, 2022, 7:00 p.m. indicated staff heard resident's tab alarm going off. Staff found resident on the floor in the main common/bird room area next to the salon room door sitting up against the door near his wheelchair. Resident is alert and doing fine. Staff called lift assist to access him and lift him. Resident was not taken to the hospital and there were no apparent injuries at this time.	01620		

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01620	Continued From page 71 -PN dated May 23, 2022, 9:20 a.m. (un-witnessed fall May 20, 2022) indicated resident did not appear to have any injuries at this time. He does like to wander and has a tab alarm in his person at all times. Interventions in place are: Tab alarm, bed alarm. Staff are instructed to walk with resident and his walker when he gets anxious. Staff will attempt to distract with coffee, food, or a Twins game when they are playing. Resident likes sports of any kind but does not always stay in one place to watch it. Staff will offer a phone call to resident's family member. If all this fails, resident has a PRN that can be given. Resident should be kept within sight when at all possible. -IR dated May 21, 2022, 3:15 p.m. indicated this writer was in the dining room assisting other residents to table for supper when resident got out of his wheelchair and fell. Immediate Action: This writer called lift assist and kept resident comfortable; resident was taken by ambulance to have large bump above his left eye checked out. On call nurse was notified. -PN dated May 23, 2022, 9:28 a.m. (un-witnessed fall May 21, 2022) indicated resident has a goose egg above his left eye. It is bruising. He states, it hurts a little bit. He was checked out at the ER and was found to have no brain bleed, or fracture. He does like to wander and has a Tabs alarm on at all times. Interventions in place are: Tab alarm, bed alarm. Staff are instructed to walk with resident and his walker when he gets anxious. staff will attempt to distract with coffee, food, or a twin's game when they are playing. Resident likes sports of any kind but does not always stay in one place to watch it. Staff will offer a phone call to resident's family member. If all this fails, resident has a PRN that can be given. Resident should be kept within sight when at all possible.	01620		

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01620	Continued From page 72 -IR dated June 5, 2022, 4:25 p.m. indicated this writer and other staff were assisting another resident with toileting. Upon returning to dining room resident was beside wheelchair on floor. Immediate action: this writer and other staff used hoyer to assist resident up back into his wheelchair. -PN dated June 6, 2022, 9:23 a.m. (un-witnessed fall June 5, 2022) indicated no injuries noted. Redirection was attempted and unsuccessful. -IR dated June 16, 2022, 5:45 p.m. indicated witnessed R4 try to stand up and he fell out of his wheelchair down onto his left shoulder, he did not hit his head and stated that he felt fine and did not have any apparent injuries. We were assisting room 103, when we heard his tab alarm ringing, he was seated in the TV/Living room, I got there in time to witness, but that was it. He was Hoyered off the floor, assessed and said he was feeling okay. Nurse did not need to be called. -PN dated July 25, 2022 (documented 39 days after occurred), 8:47 a.m. (witnessed fall June 16, 2022) indicated resident was standing up looking out the laundry room. Witness saw him fall as she was coming to get him. Resident was not injured. Resident does not know his own limitations. Tab alarm is on resident at all times. Staff attempt to keep him in eye sight, but resident is a wanderer. Staff redirect resident as much as possible by offering food, coffee, the Twins game or sports shows. If all fails resident has a PRN that can be used and is sometimes effective. -IR dated June 25, 2022, 4:50 p.m. read "I was helping another resident when I heard R4's panic alarm. I ran to see what he was doing. He was standing and walking in the living room. I approached him and tried to have him sit in his chair and he got angry. I held under his arms to	01620		

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help him calm down and sit in his chair. He started going down and I held onto him tight and I lowered him to the floor. We lowered to the floor slowly and he pretty much just sat down on the floor. He didn't hit his head or have any injuries that I am aware of. Hoyer used to lift him off the floor and put him back in his chair."
-PN dated June 28, 2022, 8:11 a.m. (fall staff assist June 25, 2022) indicated resident was not harmed. Alarms were on and staff responded quickly helping resident to the floor. Fall plan was in place and followed.

-IR dated June 27, 2022, 6:45 p.m. indicated this writer was down on south assisting other staff. 109 Tabs alarm went off and staff turned around and saw him stand himself up and try and turn. He then fell on his bottom. Immediate action: staff then went to see if he was ok. 109 said he was fine and kept saying to pick him up. 109 moved himself up into a sitting position and staff used transfer belt to lift him back into his wheelchair. 109 did bump open an existing skin tear on his right arm.
-PN dated June 30, 2022, 9:42 a.m. (witnessed fall June 27, 2022) indicated resident continues to try to ambulate without assistance. Balance if very poor. A tab alarm is on him at all times. He has a bed alarm and a chair alarm. Staff keep eyes on him whenever possible. Resident stated he was ok and not in pain. Resident has been at baseline since fall.

-IR dated June 30, 2022, 2:25 a.m. indicated resident was found in the laundry room on the floor by the back door. Appeared to have gotten up out of the wheelchair and had fallen. RN on staff was called to assess for any injury. Resident Description: I don't know what happened. Immediate Action: Resident received a skin tear

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01620	Continued From page 74 on his right wrist which was cleaned and bandaged. Resident was checked for injury and asked if he hit his head. -PN dated July 5, 2022, 9:32 a.m. (un-witnessed fall June 30, 2022) indicated resident was helped up in his chair and displayed no injury except the scrape on his wrist. Tab alarm was in place. Resident had just been toileted. Staff offered food interventions as well as Twins game. Resident at baseline. -IR dated July 4, 2022, 2:11 p.m. indicated resident got up from wheelchair in the laundry room, and staff witnessed him fall to the ground on his back. Staff asked the resident if he was hurt, resident told staff he was not hurt. Immediate Action: Staff called for assistance to help him get off floor, and back into his wheelchair. -PN dated July 5, 2022, 9:06 a.m. (witnessed fall July 4, 2022) indicated resident was standing up looking out the laundry room. Witness saw him fall as she was coming to get him. Resident was not injured. Resident does not know his own limitations. Tab alarm is on resident at all times. Staff attempt to keep him in eye site, but resident is a wonderer. Staff redirect resident as much as possible by offering food, coffee, the Twins game or sports shows. If all fails resident has a PRN that can be used and is sometimes effective. -PN dated July 25, 2022, 8:44 a.m. Incident Note: No injury noted. Fall interventions were in place. Resident is impulsive and does not understand his limitations. Staff continue to keep a close eye on him but it's difficult when staff are in with another resident. R4's record lacked evidence of an IR for the above PN note dated July 25, 2022.	01620		

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01620	Continued From page 75 -IR dated August 5, 2022, 6:34 p.m. indicated witnessed fall in South Dining room at 6:34 PM. I was returning from break to hear his tab alarm; he was walking into the kitchen. I tried to get a dining room chair behind him, but I was not fast enough, he made an attempt to sit but he was uncoordinated and missed. I was not able to catch his fall. He fell hard onto his left shoulder. Complained of no pain but not eager to move. Lift assist was called. Noticed later on during cares that he had a lump and abrasion on his left knee. It was cleaned and bandaged. Resident Description: Resident stated that he felt okay. Immediate Action: sat with R4 and kept him still so he did not move. Per the request of lift assist, I sat with him from 6:35-7:31. Lift assist cleared him medically and got him back into his wheelchair. Did not need to be transported. -PN dated August 8, 2022, 1:50 p.m. (witnessed fall August 5, 2022) indicated resident frequently falls due to memory loss and confusion. Resident does not know his limits. Resident has a tab alarm on at all times. Staff attempt to keep him within sight, but resident is impulsive and thinks he can still walk independently. He has a bed and chair alarm as well. R4's record lacked evidence of a documented comprehensive assessment by the RN for a change in condition related to the falls as noted above (injury/ER visit), lacked notification of nurse regarding fall as noted above and lacked documented evidence of review for causative factors including review of interventions consistently to determine if new interventions should be implemented to minimize the risk for future falls and potential injury. On August 29, 2022, at 12:23 p.m. during the entrance conference RN-C stated regarding the	01620		

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licensee process for falls, unwitnessed fall lift assist is called (911 non-emergency). Lift assist assesses and move off floor if I am not here. If lowered to the floor, they call the person on-call and if fine, no pain, help lift up. Incident report is filled out. I go over the incident report, check with resident if everything is all right. If there is a broken hip or a serious injury a MAARC report is submitted. I assess the resident for physical/mental and check for no injury. LALD-A and I sign off on the incident to check proper procedure followed/gait belt used, if not retrain. Call the family for all falls. Monitor and go over falls for root cause (look for) and change something in care plan if need too.

On September 1, 2022, at approximately 11:50 a.m. RN-C stated the resident progress notes was where she documented her follow ups for falls and what she did for the fall would be documented in the progress note. RN-C stated she would update care plan with any changes. RN-C stated if injury she would compete a comprehensive assessment but not if there was no injury. The surveyor asked for documentation of any comprehensive assessments completed by RN-C for the above falls. No further information was provided.

R1
R1's comprehensive assessment lacked documented evidence of a physical assessment of R1, which included vital signs and lung sounds at the time the comprehensive assessment was completed by the RN.

R1's diagnoses included hypertension (high blood pressure), diabetes (too much sugar in the blood) and sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and

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01620	Continued From page 77 starts). R1's Service Plan was signed by LALD-A on April 27, 2022, and by R1's resident/responsible party on June 21, 2022. R1's service plan indicated R1 received services including support network, activities, case management, financial care management, housekeeping, laundry, manage environment, personal shopping, transportation, bathing, dressing/undressing, eating/meals, mobility, toileting, diabetes management, medication administration, medication management (medication set/administration), medication monitoring/admin and reminders, emergency response, general safety, medication management coordination, hearing, abuse risk/vulnerability. R2's 90-day assessment dated August 2, 2022, lacked a physical assessment by the RN which included vital signs and checking lung sounds. The assessment identified for respiratory function "4. Lung Sounds - describe:" had no documented information by the RN for assessment of lung sounds and there was no documented evidence of vital signs being taken by the RN for the area of "Monitoring Required" indicating "Monitor pulse, respiration, blood pressure, and weight monthly". R2 R2's comprehensive assessment lacked accurate assessment for abuse and documented evidence of a physical assessment of R2, which included vital signs and lung sounds at the time the comprehensive assessment was completed by the RN. R2's diagnosis included unspecified dementia without behaviors, chronic obstructive pulmonary disease, respiratory failure with oxygen	01620		

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dependence, hypertension and osteoarthritis.

R2's Service Plan dated August 3, 2022, was signed by LALD-A on August 11, 2022, and by resident/responsible party on August 13, 2022, indicated R2 received services including bathing, toileting, dressing, meal (set up), housekeeping, laundry, transfers, walking standby/supervision, wheelchair mobility, medication management, escorts to meals, case management, hygiene, activities, respiratory equipment, financial/care management, and overnight safety checks.

R2's initial assessment dated August 3, 2022, lacked a physical assessment by the RN which included vital signs and checking lung sounds. The assessment identified for respiratory function "4. Lung Sounds - describe:" had no documented information by the RN for assessment of lung sounds and there was no documented evidence of vital signs being taken by the RN for the area of "Monitoring Required" indicating "Monitor pulse, respiration, blood pressure, and weight monthly."

R2's 14-day assessment dated August 15, 2022, also lacked evidence of a physical assessment as above.

In addition, the assessment section "F. Vulnerability" a check mark was placed in the box next to option "1. Is not at risk to be abused."

On September 1, 2022, at approximately 5:05 p.m. LALD-A and RN-C stated that R2 was not vulnerable to abuse as she can "yell for help." With further discussion LALD-A agreed all residents were vulnerable to abuse. RN-C stated with her comprehensive assessment, she does

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vital signs at time of admission but for the 14 day/90 day assessments she often times looks at the vital signs as documented most recently by the ULP and enters them with her assessment. RN-C stated she checks lung sounds "with symptoms". RN-C stated she does not check lung sounds with every 90-day assessment.

The licensee's Reporting, Documenting, and Reviewing Incidents Involving Residents policy dated October 11, 2022, indicated incidents involving residents would have a corresponding incident report and follow up would be completed as appropriate. Staff discovering an incident involving a resident immediately calls the licensed nurse on-site. If there is no nurse on site available, staff would update the on call RN and follow direction from the nurse. The RN would complete an assessment of the resident in a time frame the was reasonable following the incident. The RN would document in the resident's chart the details of any incident involving the resident and their assessment including the follow-up actions that were taken.

The licensee's Falls policy dated October 13, 2021, indicated for witnessed fall: in the event of a fall during business hours when an RN was in the building staff would call the RN to come and assess the resident. Based on the RN's assessment (vitals, pain, type/site of injury EMS/lift assist may be called). If the resident is stable no injuries noted the RN will instruct the staff to write up an incident report. The RN would document the incident in a progress notes section of the incident report. The RN would look at interventions as appropriate for the resident to prevent falls. If the fall was a result of staff training issues/education the RN would retrain staff to processes. If the Resident fell and injuries

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01620	Continued From page 80	01620		

are note the RN/staff would call EMS. The resident would be transported to the local ER for evaluation. The RN would document the incident in a progress notes section of the incident report. The RN would look at interventions as appropriate for the resident to prevent falls. The RN would write up a MAARC report if appropriate to do so. Unwitnessed Fall: In the event of a fall after business hours when an RN was not in the building: staff would take vital signs, check for open areas, ask if resident has pain, and call the RN on call. Based on the RN's assessment via the call with staff (and information given on vitals, pain, type/site of injury EMS/lift assist may be called) If the resident was stable no injuries noted the RN would instruct the staff to write up an incident report. The RN would document the incident in a progress notes section of the incident report. The RN would look at interventions as appropriate for the resident to prevent falls. If the fall was a result of staff training issues/education the RN would retrain staff to processes. If the Resident fell and injuries are noted by the staff: The Staff would take vital signs, check for open areas, ask if resident has pain. Staff were to call the RN on call (if the RN does not answer and it is an emergency do not hesitate to call EMS). If EMS was called and the resident was transported to the local ER for evaluation. The RN would document the incident in a progress notes section of the incident report. The RN would look at interventions as appropriate for the resident to prevent falls. If the fall was a result of staff training issues/education the RN would retrain staff to processes. The RN will write up a MAARC report if appropriate to do so.

The licensee's Initial and On-Going Nursing Assessment of Residents under the

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01620	Continued From page 81 Comprehensive Licensed Agency policy dated October 11, 2021, indicated the RN would reassess the resident if the resident has a change in condition. At these re-assessments, the RN would: review the resident's service plan, evaluate the resident's medication management services and the resident's medications, evaluate the resident's treatments if any, communicate any new problems or concerns to the resident's physician or health care providers, and update the service plan as necessary based on the resident's needs. No other information 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. (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,	01640		

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01640	Continued From page 82 including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure signature by the resident/responsible party when the service plan was revised by the licensee and failed to ensure the service plan was revised, based on resident assessment for two of two residents (R1, R2). 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: R1 The licensee failed to obtain a signature from the resident/responsible party at the time the service plan was signed by the provider and lacked revision of the service plan to include grooming and the treatment service of continuous positive airway pressure (CPAP). R1's diagnoses included sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts).	01640		

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01640	Continued From page 83 R1's Service Plan was signed by licensed assisted living director (LALD)-A on April 27, 2022, and was signed by R1's resident/responsible party on June 21, 2022. R1's service plan indicated R1 received services including support network, activities, case management, financial care management, housekeeping, laundry, manage environment, personal shopping, transportation, bathing, dressing/undressing, eating/meals, mobility, toileting, diabetes management, medication administration, medication management (medication set/administration), medication monitoring/admin and reminders, emergency response, general safety, medication management coordination, hearing, abuse risk/vulnerability. On August 30, 2022, at 6:12 a.m. unlicensed personnel (ULP)-D was observed to shut of CPAP machine, removed R1's CPAP mask, placed the CPAP mask into a container which cleansed the CPAP mask, assisted R1 wash their face and provided eye glasses. R1's 90-day Assessment dated August 2, 2022, indicated for for "hygiene/grooming SP. Service Planning: resident will receive assistance hygiene/grooming. Needs some help or set up assist with grooming/hygiene (teeth, dentures, hair), respiratory equipment, no oxygen needs." The assessment did not identify R1 utilized a CPAP. R1's Service Plan lacked signature of R1's resident/responsible party at the time the LALD-A signed the service plan on April 27, 2022, lacked revision for providing the service of grooming/hygiene based on R1's assessment	01640		

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01640	Continued From page 84 dated August 2, 2022, and for the treatment service of CPAP. On September 1, 2022, at approximately 5:10 p.m. LALD-A confirmed the contract was signed by her on April 27, 2022, and R1's resident/responsible party had not signed the service plan until June 21, 2022 (55 days). LALD-A stated the delay for obtaining R1's resident/responsible party signature was "because I had 100 people to do" for service plan changes. At that time, registered nurse (RN)-C confirmed R1 utilized a CPAP. RN-C reviewed R1's 90-day assessment and verified CPAP was not indicated on the assessment but should have been. RN-C confirmed R1's service plan did not include the treatment service of CPAP. RN-C stated the resident assessment populates tasks assigned to staff and the service plan, therefore CPAP would not be on R1's service plan due to not being identified on R1's assessment. LALD-A stated herself and RN-C approve the service plan then LALD-A approves and signs the service plan with family. R2 The licensee failed to obtain a signature from the resident/responsible party at the time the service plan was signed by the provider and lacked revision of R2's service plan to include the treatment services of TED (thrombo embolic deterrent) stockings (compression stockings used to reduce edema) and oxygen. R2's diagnoses included unspecified dementia without behavioral disturbance, hypertension, chronic obstructive pulmonary disease, respiratory failure with oxygen dependence and edema. R2's Service Plan dated August 3, 2022, was	01640		

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01640	Continued From page 85 signed by LALD-A on August 11, 2022, and by R2's resident/responsible party on August 13, 2022. R2's service plan indicated R2 received services including bathing, toileting, dressing, meal (set up), housekeeping, laundry, transfers, walking standby/supervision, wheelchair mobility, medication management, escorts to meals, case management, hygiene, activities, respiratory equipment, financial/care management, and overnight safety checks. On August 30, 2022, at approximately 6:40 a.m. ULP-E was in R2's room and observed providing morning cares. ULP-E provided care that included TED stocking placement to R2's lower limbs as well as assistance with placement of oxygen tubing to R2's face and assured oxygen flow from the concentrator was at the designated setting as ULP-E stated to be "two liters". R2's 14-day Assessment dated August 15, 2022, indicated "SP. Service Planning: Respiratory equipment-needs help with oxygen equipment-change oxygen tubing", and "needs help with nebulizer use." R2's Task sheet dated August 2022, indicated "Ted Hose assist" and "Oxygen tubing" with no specific instruction or detail. R2's Service Plan lacked revision for providing the treatment services of TED stockings and oxygen equipment services further than changing tubing. On September 1, 2022, at approximately 6:00 p.m. RN-C verified R2's service plan lacked revision for providing the treatment services of TED stockings and oxygen equipment services further than changing tubing.	01640		

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01640	Continued From page 86 The licensee's Contents of Service Plans policy dated October 18, 2021, indicated all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional. A proposed service plan is established after completion of individualized, initial assessment. A finalized service plan will be completed no later than 14 calendar days after initiation of services. Service plans and any revisions to services plans would have a signature or other authentication by the facility and by the resident. Other authentication could be email confirmation accepting terms of a service agreement or other method deemed appropriate by the assisted living. Service plans were reviewed and revised as needed based upon on-going resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff	01650		

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providing services; and
(5) a contingency plan that includes:
(i) the action to be taken if the scheduled service cannot be provided;
(ii) information and a method to contact the facility;
(iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and
(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure the service plan included all required content for two of two residents (R1, R2).

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:

R1

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01650	Continued From page 88 R1's diagnoses included hypertension (high blood pressure), diabetes (too much sugar in the blood) and sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts). R1's Service Plan was signed by licensed assisted living director (LALD)-A on April 27, 2022, and was signed by R1's resident/responsible party on June 21, 2022. R1's service plan indicated R1 received services which included support network, activities, case management, financial care management, housekeeping, laundry, manage environment, personal shopping, transportation, bathing, dressing/undressing, eating/meals, mobility, toileting, diabetes management, medication administration, medication management (medication set/administration), medication monitoring/admin and reminders, emergency response, general safety, medication management coordination, hearing, abuse risk/vulnerability. On August 30, 2022, at 6:12 a.m. unlicensed personnel (ULP)-D was observed to assist R1 with CPAP equipment, transfer utilizing a platform and mechanical stand, dressing, assist onto toilet, change an incontinent product, wash face, provide eye glasses, make the bed and remove the garbage. At 6:31 a.m. ULP-H stated she worked evenings and night shift and during the shifts, staff checked R1's blood sugar on Tuesday and Friday evenings, assisted R1 to undress, assisted R1 to bathe on Friday evening, checked to make sure incontinent product was dry, assisted with putting on CPAP and transferred R1 into bed utilizing the platform stand. At 8:28 a.m., ULP-D was observed to administer R1's medications.	01650		

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01650	Continued From page 89 R1's Task sheet dated August 2022, identified staff were signing for providing the services of bathing twice weekly, daily COVID-19 screening, monthly vitals, blood sugar check twice weekly, behavior interventions as needed, bladder incontinence routine every shift, towel change daily, bathing assist additional, well check night, bowel incontinence, reorientation/cueing, daily waste, daily bed make, housekeeping weekly and laundry weekly. Dressing task lacked documented evidence of staff providing the service. R1's Service Plan lacked the following: - description of services for treatments (CPAP and grooming.) - the fees for services (all services) and the frequency of each service (lacked for some services). - the schedule and methods of monitoring assessments of the resident. - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those	01650		

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01650	Continued From page 90 chapters. On September 1, 2022, at approximately 5:10 p.m. LALD-A confirmed the contract was signed by her on April 27, 2022 and R1's resident/responsible party on June 21, 2022. At the time registered nurse (RN)-C confirmed R1 utilized a CPAP. RN-C reviewed R1's 90-day assessment and verified CPAP was not indicated on the assessment but should have been. RN-C confirmed R1's service plan did not include the treatment service of CPAP. RN-C stated the resident assessment populates tasks assigned to staff and the service plan, therefore CPAP would not be on R1's service plan due to not being identified on R1's assessment. LALD-A stated herself and RN-C approve the service plan then LALD-A approves and signs the service plan with family. LALD-A and RN-C confirmed R1's service plan lacked the above. R2 R2's diagnoses included, but was not limited to, unspecified dementia without behavioral disturbance, hypertension, chronic obstructive pulmonary disease, respiratory failure with oxygen dependence, and unspecified edema. R2's Service Plan dated of August 3, 2022, was signed by licensed assisted living director (LALD)-A on August 11, 2022, and by resident/responsible party on August 13, 2022, indicated R2 received services which included bathing, toileting, dressing, meal (set up), housekeeping, laundry, transfers, walking standby/supervision, wheelchair mobility, medication management, escorts to meals, case management, hygiene, activities, respiratory equipment, financial/care management, and overnight safety checks. The service plan did not	01650		

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01650	Continued From page 91 identify R2 received assistance with treatments service of TED stockings and lacked description of oxygen equipment services further than changing tubing. On August 30, 2022, at approximately 6:40 a.m. ULP-E was observed to assist R2 with TED stockings, oxygen tubing on and off placement assuring oxygen flow was at proper two liters stating that R2 "likes her oxygen tubing off of her face while she is changing clothing," bathing, dressing assistance, incontinence pad check and change, lotion to skin, bed making, trash removal and transfers with stand-by assistance for walking. R2's Task sheet dated August 2022, identified staff were signing for providing the services of dressing, bathing, bowel incontinence, routine toileting and incontinence pad checks, oxygen tubing, monthly vital signs, behavior interventions, towel change, Ted hose assist, transfers to and from chair, daily bed making, laundry, every two hour well check during overnight, laundry weekly, housekeeping weekly, food set up at meals and daily COVID-19 screening. R2's Service Plan lacked the following: - description of services for treatments (TED stockings, oxygen equipment management) - the fees for services (all services) and the frequency of each service (lacked for some services). - the schedule and methods of monitoring assessments of the resident. - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided;	01650		

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(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
01650	Continued From page 92 (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On September 1, 2022, at approximately 6:00 p.m. LALD-A stated regarding missing contents of the service plan, she thought "these pieces were somewhere in Point Click Care [electronic record system], but cannot find them. We will need to add these to the service plan." The licensee's Contents of Service Plans policy dated October 18, 2021, indicated service plans would include the required content as according to the assisted living statute 144G.70 Subd.4.(f.). No Further information provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides	01690		

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	28411	A. BUILDING: _____ B. WING _____	09/01/2022

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01690	Continued From page 93 medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written medication management policies and procedures. 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	01690		

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01690	Continued From page 94 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 29, 2022, at 12:23 p.m. director of nursing (DON)-B confirmed the licensee provided medication management services. A request was made to review the licensee's policies and procedures. The licensee lacked the following required policies: -verifying that prescription drugs are administered as prescribed; -monitoring and evaluating medication use; -resolving medication errors; -educating residents and legal and designated representatives about medications On September 1, 2022, at approximately 4:24 p.m. DON-B verified the licensee lacked the above policies and procedures for medication management. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to	01700		

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providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.
(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review the licensee failed to ensure assessment of medication management services for two of two residents (R1, R2).

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

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than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R1 had an admission date of July 19, 2021, with diagnoses including hypertension (high blood pressure) and diabetes (too much sugar in the blood).

R1's Service Plan was signed by licensed assisted living director (LALD)-A on April 27, 2022, and was signed by R1's resident/responsible party on June 21, 2022, and indicated R1 received services including diabetes management, medication administration, medication management (medication set/administration), medication monitoring/admin and reminders and medication management coordination.

On August 30, 2022, at 8:28 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R1.

On August 31, 2022, at 11:14 a.m. registered nurse (RN)-C was observed to setup one week of R1's medications into a medication box for the days of Sunday through Saturday. R1's Medication Administration Record (MAR) dated September 2022, identified the nurse was providing the service of medication set up.

R1's MAR dated August 2022, indicated staff were administering two medications for blood pressure, one medication for heart disease, one medication for mood stabilizer, one medication for Parkinson's disease (a disorder that affects movement, often including tremors), three

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medications for supplement, one medication to prevent blood clots, one medication for diabetes, one medication for nerve pain, one medication for management of angina (a type of chest pain), one medication for bladder muscle relaxing and one medication used to treat heartburn/indigestion.

R1's record lacked an assessment to determine what medication management services would be provided and how the services would be provided prior to providing medication management services by the RN, to include the following:
-documentation the assessment was conducted face-to-face with the resident;
-identification and review of all medications the resident is known to be taking, which included indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; and
-identification of interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.
R2
R2 had an admission date of August 3, 2022, with diagnoses including unspecified dementia without behavioral disturbance, hypertension, chronic obstructive pulmonary disease, respiratory failure with oxygen dependence, and unspecified edema.

R2's Service Plan was signed by LALD-A on August 11, 2022, and was signed by R2's resident/responsible party on August 13, 2022, and indicated R2 received services including medication management, medication

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01700	Continued From page 98 monitoring/admin and reminders and medication management coordination. On August 30, 2022, at approximately 8:03 a.m. ULP-D was observed to set up and administer R2's medication in the facility dining hall. R2's MAR dated August 2022, indicated staff were administering one medication for high cholesterol, one inhaler and one nebulizer for shortness of breath, one medication as a supplement, one medication for dementia, one medication to balance electrolytes, one medication for depression, one medication for edema (water retention), one medication for high blood pressure, one blood thinner to prevent blood clots, two medications for constipation, and one medication for mild pain. R2's record lacked an assessment to determine what medication management services would be provided and how the services would be provided prior to providing medication management services by the RN, to include the following: -documentation the assessment was conducted face-to-face with the resident; -identification and review of all medications the resident is known to be taking, which included indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; and -identification of interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.	01700		

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01700	Continued From page 99 On September 1, 2022, at approximately 5:10 p.m. RN-C confirmed R1 and R2's records lacked a medication assessment as required. RN-C stated she was "not aware" of the requirement. RN-C stated medication orders were inputted by the pharmacy into the computer program utilized and contraindications of medications would automatically come up if there were any. The licensee's Medication Management policy dated October 21, 2021, indicated staff would provide medication management services only after a face-to-face assessment has been performed by our Registered Nurse. The assessment would include a review of all the medications the resident is taking including herbals and those they have purchased over the counter. The assessment was to include reason taken, side effects, contraindications, allergic or adverse reactions, actions to address side effects, contraindications, allergic or adverse reactions, dosage, frequency of use, route administered, resident difficulties taking medications, self-administration vs. other type of administration. resident preferences for taking medications, medication management interventions to prevent drug diversion by the resident or others who have access to medications and instructions to the resident and resident's legal/designated representatives on interventions to manage the resident's medications and prevent medication diversion. The assessment would include the indications for medications, the side effects, contraindications, allergic or adverse reactions and actions to address identified issues. The assessment would also include the risk for diversion, level of medication management to be provided and how they will be provided.	01700		

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01700	Continued From page 100 No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01700		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use	01730		

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01730	Continued From page 101 to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individualized medication management plan was developed to include all required content for two of two residents (R1, R2). 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: R1 R1's Service Plan signed by licensed assisted living director (LALD)-A on April 27, 2022, and R1's resident/responsible party on June 21, 2022, indicated R1 received services which included diabetes management, medication administration, medication management (medication set/administration), medication monitoring/admin and reminders and medication	01730		

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01730	Continued From page 102 management coordination. On August 30, 2022, at 8:28 a.m. unlicensed personnel (ULP)-D was observed to administer medications to R1. On August 31, 2022, at 11:14 a.m. registered nurse (RN)-C was observed to setup one week of R1's medications into a medication box for the days of Sunday through Saturday. R1's Medication Administration Record (MAR) dated September 2022, identified the nurse was providing the service of medication set up. R1's 90-day assessment dated August 2, 2022, indicated for medication management RN sets up medications weekly and staff give them. The assessment indicated client specific instructions related to the administration, monitoring and documentation of medications specify: medications will be given according to the signed provider orders on the eMAR (electronic MAR). Method for ULP to contact the nurse if questions or concerns arise re: medication management and administration: There is a nurse on call 24/7. The phone numbers are posted on the nurse on call calendar, on the staff phone list. Staff may call or text questions/issue 24/7. R1's MAR dated August 2022, indicated staff were administering two medications for blood pressure, one medication for heart disease, one mood stabilizer, one medication for Parkinson's disease (a disorder that affects movement, often including tremors), three supplements, one medication to prevent blood clots, one medication for diabetes, one medication for nerve pain, one medication for management of angina (a type of chest pain), one bladder muscle relaxant and one medication used to treat heartburn/indigestion.	01730		

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01730	Continued From page 103 R1's MAR lacked specific medication instructions for medication administration including how the medications should be taken. R1's record lacked documented evidence when the nurse should be notified for problems related to the administration of one medication to prevent blood clots, which was clopidogrel bisulfate (Plavix) (increases the risk of bleeding). In addition, R1's individualized medication management record did not address the following: -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On September 1, 2022, at approximately 5:10 p.m. RN-C confirmed R1's MAR lacked specific instructions of how the medications should be taken. RN-C confirmed R1's record did not indicate when to notify the nurse for problems related to the administration of clopidogrel bisulfate. RN-C confirmed R1's individualized medication management record did not address any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. RN-C stated she was "not sure what that means." R2 R2's Service Plan dated August 3, 2022, was	01730		

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01730	Continued From page 104 signed by LALD-A on August 11, 2022, and signed by R2's resident/responsible party on August 13, 2022, indicated R2 received services including medication management. On August 30, 2022, at approximately 8:03 a.m. ULP-D was observed to administer R2's medications. R2's MAR dated August 2022, indicated staff were administering one medication for high cholesterol, one inhaler and one nebulizer for shortness of breath, one supplement, one medication for dementia, one medication to balance electrolytes, one medication for depression, one medication for edema (water retention), one medication for high blood pressure, one blood thinner to prevent blood clots, two medications for constipation, and one medication for mild pain. R2's 14-day assessment dated August 15, 2022, indicated "specific instructions related to the administration, monitoring and documentation of medications specify: Medication will be give [sic] according to the signed provider orders on the eMAR", and "Method for unlicensed personnel (ULP) to contact the nurse if questions or concerns arise re: medication management and administration: "There is a nurse on call 24/7. The phone numbers are posted on the nurse on call calendar, on the staff phone list, Staff may call or text questions/issue 24/7." R2 received apixaban (blood thinner) twice daily to prevent blood clots. R2's prescriber's order dated August 15, 2022, indicated Albuterol sulfate nebulizer every six hours as needed for shortness of breath.	01730		

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01730	Continued From page 105 R2's record lacked documented evidence when the nurse should be notified for problems related to the administration of apixaban, lacked direction regarding when ULP should contact nursing for use of Albuterol sulfate nebulizer and lacked instruction for properly cleaning and storing of nebulizer equipment. Additionally, R2's individualized medication management record lacked required content for the following: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. R2's 14-day assessment indicated plan for schedule II, III, and IV controlled medications but failed to include the plan for securing all other medications. - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On September 1, 2022, at approximately 6:20 p.m. RN-C confirmed that R2's record lacked the above. The licensee's Medication Management policy dated October 21, 2021, indicated the licensee had included a description of the medication management services that would be provided below and; A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions is listed on the MAR and in the RN assessment. Documentation of specific resident instructions relating to the	01730		

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01730	Continued From page 106 administration of medications for our staff on the MAR. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. Identification of medication management tasks that may be delegated to unlicensed personnel are listed on the MAR. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services as listed on the instructions to the ULP. Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. The MAR will be current and updated when there are any changes. Ongoing medication reconciliation will be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. If we store any medications, they will be stored at the temperature recommended by the manufacturer and kept in a substantially constructed and in a locked storage compartment with access allowed only by identified staff. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days	01730		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation	01760		

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01760	Continued From page 107	01760		

must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure documented dosage for medications for one of three residents (R1) and failed to notify the physician and address if there was a negative outcome for omission (not given as prescribed) of medication for one of one resident (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:

R1
R1's record lacked documented dosage for medications being administered.

On August 30, 2022, at 8:28 a.m. unlicensed personnel (ULP)-D was observed to remove 12 pills from a medication cassette and administer

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01760	Continued From page 108 the medications to R1. R1's Medication Administration Record (MAR) dated August 2022, included the following: -amlodipine besylate give one tablet by mouth one time a day (used for high blood pressure) -cholecalcif give two tablets by mouth one time a day (used for supplement) -clopidogrel bisulfate give one tablet by mouth one time a day (used for blood clot prevention) -magnesium oxide give two tablets by mouth three times a day (used for supplement) R1's MAR lacked medication dosage to be administered as noted above. On September 1, 2022, at approximately 5:10 p.m. RN-C confirmed R1's MAR dated August 2022, lacked medication dosage to be administered as noted above. RN-C stated she would have to clarify the dosage with R1's physician. R4 R4's Medication Error report dated June 1, 2022, documented by unlicensed personnel (ULP)-H indicated "resident was supposed to have 6 mg [milligrams] warfarin on Wednesday and have 4 mg the other days, but didn't get medication at all, or it was taken out of the bubble pack for a different day. A different staff did this mistake." R4's Progress Note dated June 6, 2022, documented by RN-C indicated "writer talked to staff member who made the error. She stated she missed it because it had been shoved in the back of the drawer. Writer educated staff member to always read the MAR [medication administration record] and if a medication is missing, ask or call the nurse. Staff member verbalized	01760		

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01760	Continued From page 109 understanding." R4's record lacked documented evidence R4's physician was notified of the missed dose of warfarin and if there was any negative outcome. On August 31, 2022, at 2:23 p.m. RN-C stated she had not documented the name of the staff person who made the medication error, but the staff person was ULP-D. RN-C stated she had not notified R4's physician of the medication error. RN-C verified there was no documentation in R4's record whether there was a negative outcome. RN-C stated if there was a negative outcome she would have documented that in R4's chart. RN-C stated, "There was nothing negative that I know of." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documented dosage for medications setup for one of three residents (R1).	01770		

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01770	Continued From page 110	01770		

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

On August 31, 2022, at 11:14 a.m. registered nurse (RN)-C was observed to setup one week of R1's medications into a medication box for the days of Sunday through Saturday and signed for setup of the medications between the dates of September 1 through September 7, 2022.

R1's Medication Administration Record (MAR) dated September 2022, used for documentation of medication setup by RN-C included the following:
-amlodipine besylate give one tablet by mouth one time a day (used for high blood pressure)
-cholecalcif give two tablets by mouth one time a day (used for supplement)
-clopidogrel bisulfate give one tablet by mouth one time a day (used for blood clot prevention)
-magnesium oxide give two tablets by mouth three times a day (used for supplement)

R1's MAR dated September 2022, lacked documented quantity of dose for the above medications at the time RN-C setup the medications.

On September 1, 2022, at approximately 5:10 p.m. RN-C confirmed all of the above. RN-C further stated she would have to clarify the

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01770	Continued From page 111 dosage to be given with R1's physician. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated October 4, 2021, indicated the RN would document the services the resident would receive on the resident's individualized medication management plan and individualized treatment and therapy plan and client's medication/treatment record or MAR/TAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement policies and procedures for giving accurate and current medications for those residents who received	01780		

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01780	Continued From page 112	01780		

medication management services during planned or unplanned times away from home. This has the potential to affect all residents.

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

The findings include:

The licensee's Delegation of Medications to be Given to Clients by Unlicensed Staff for Clients Time Away From Home "Document No: NUR 1.0" and Document No: MED 1.0" policies dated October 24, 2021, did not address the following as required:
-for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice;

On September 1, 2022, at 11:00 a.m. registered nurse (RN)-C stated regarding unlicensed personnel sending medications with residents when they leave the facility, "yes, they do send meds out".

On September 1, 2022, at approximately 4:24 p.m. director of nursing (DON)-B verified the above policies lacked the required content as above.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7)

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01780	Continued From page 113 days	01780		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to	01790		

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01790	Continued From page 114 be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement policies and procedures for medication management services during unplanned times away from home. This has the potential to affect all residents. In addition, the licensee failed to ensure training and competency evaluations for preparing medications for resident unplanned times away were completed as required for two of two unlicensed personnel (ULP-D, ULP-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01790		

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01790	Continued From page 115 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: The licensee's Delegation of Medications to be Given to Clients by Unlicensed Staff for Clients Time Away From Home "Document No: NUR 1.0" and Document No: MED 1.0" policies dated October 24, 2021, did not address the following as required: -the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and -the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. -the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; -a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel	01790		

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01790	Continued From page 116 TRAINING/COMPETENCY ULP-D had a hire date of December 19, 2011. ULP-E had a hire date of June 27, 2022. ULP-D and ULP-E's records lacked evidence to indicate the registered nurse (RN) provided training and determined competency to prepare and administer medications to residents for unplanned times away. On September 1, 2022, at 11:11 a.m. RN-C stated regarding unlicensed personnel sending medications with residents when they leave the facility, "yes, they do send meds out". RN-C stated, "I don't think so" regarding providing training and competency of ULP for preparing medications for residents unplanned time away. RN-C confirmed all the licensee ULP would lack the training and competency. On September 1, 2022, at approximately 4:24 p.m. director of nursing (DON)-B verified the above policies lacked the required content as above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.	01820		

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01820	Continued From page 117 This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure prescriber's orders included the medication dose for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 30, 2022, at 8:28 a.m. unlicensed personnel (ULP)-D was observed to remove 12 pills from a medication cassette and administer the medications to R1. R1's prescriber's orders dated April 14, 2022, included the following: -amlodipine besylate give one tablet by mouth one time a day (used for high blood pressure) -cholecalcif give two tablets by mouth one time a day (used for supplement) -clopidogrel bisulfate give one tablet by mouth one time a day (used for blood clot prevention) -magnesium oxide give two tablets by mouth three times a day (used for supplement) R1's Medication Administration Record (MAR) dated August 2022, indicated the same. R1's prescriber's orders lacked the dosage for the amount of medication to be given for the above	01820		

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01820	Continued From page 118 medications. On September 1, 2022, at approximately 5:10 p.m. RN-C confirmed R1's prescriber orders dated April 14, 2022, lacked the dosage for the above medications. RN-C stated she would have to clarify the dosage with R1's physician. The licensee's Medication Management policy dated October 21, 2021, indicated records of medication orders, medication administration and specific instructions are maintained in residents' permanent record. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated October 4, 2021, indicated for Receiving and Requesting Prescriptions and Refills; the nurse would document actions to implement a new prescription when it is received, and actions to request and obtain needed refills for residents, including communications with the prescriber and pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	01880		

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01880	Continued From page 119 Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to manufacturer's instructions in one of one medication refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee failed to monitor the temperature of a medication refrigerator consistently to ensure medications were stored according to manufacturer's instructions. The Daily Refrigerator Temperature Log dated August 2022, indicated documented temperatures below 36 degrees occurred on August 2, 6, 7, 10, 12, 13, 14, 16, 19, 21, 23, 24, 26, 27, 30, 31 and there were no documented temperatures for the dates of August 1, 4, 8, 11, 15, 17, 18, 20, 22, 28 and 29. On August 30, 2022, at 9:58 a.m. the refrigerator in the medication room was observed with unlicensed personnel (ULP)-G. ULP-G confirmed the refrigerator temperature to be 30 degrees Fahrenheit (F) at that time. The refrigerator contained one or more of the following medications: -a sealed envelope with "insulin" (used for diabetes/blood sugar control) written on the	01880		

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package for R2;
-lorazepam (antianxiety medication) oral liquid;
-lantanoprost (used to lower pressure inside the eye) eye drops; and
-Tubersol (three vials) (medication used to test for Tuberculosis)

On August 31, 2022, at 10:03 a.m. registered nurse (RN)-C stated the insulin in the refrigerator was "Lantus insulin pens." RN-C stated R2's family member asked for the medication to be kept for a while in case R2 would need the insulin again. RN-C stated R2 had been changed from insulin medication to oral medication for his diabetes on December 22, 2021.

The manufacturer's instructions provided by the licensee for Lantus SoloStar insulin pens dated November 2019, indicated keep your SoloStar in cool storage (36 to 46 degrees F) until first use.

The manufacturer's instructions provided by the licensee for lorazepam dated revised October 2017, indicated store lorazepam at a cold temperature. Refrigerate at (36 to 46 degrees F) and protect from light.

The manufacturer's instructions provided by the licensee for lantanoprost indicated store unopened bottle(s) under refrigeration (36 to 46 degrees F).

The manufacturer's instructions provided by the licensee for Tubersol indicated store at (35-46 degrees F) do not freeze.

On August 31, 2022, at 10:03 a.m. RN-C stated she was "not aware" some temperatures for the refrigerator were 35 degrees or lower. RN-C stated staff were to record the temperature of the

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01880	Continued From page 121 refrigerator "daily." RN-C stated staff were trained the temperature was "to be between 37 and 40 degrees, and if not let her know." The licensee's Storage of Medications policy dated October 6, 2021, indicated when secured storage of the medications is necessary, the RN would identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. Any refrigerated medication would be stored in a refrigerator that was temperature monitored daily. If a temperature was noted to be out of range, please report that to the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to keep medication in the original container dispensed by the pharmacy which was stored in one of two medication carts (north side).	01890		

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01890	Continued From page 122 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 30, 2022, at 8:43 a.m. observation of the north side medication cart with unlicensed personnel (ULP)-D identified four separate vials of refresh eye drops were stored in the space for R2 in the medication cart; however, there was no name on the vials and there was no original container in which the medication was dispensed located in the medication cart. ULP-D confirmed the findings. On August 31, 2022, at 10:03 a.m. registered nurse (RN)-C stated the staff were "supposed to keep the box [the container the medication came in from the pharmacy] in the bottom drawer of the cart. If they don't keep the medication in there [the container] then I need to have the box in there." The licensee's Storage of Medications policy dated October 6, 2021, indicated until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name,	01890		

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01890	Continued From page 123 prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. An over-the-counter drug must be kept in the original labeled container from the pharmacy or manufacturer. A sample of medication provided to the resident by an authorized prescriber must be kept in its original container bearing the original label with legible directions for use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 124 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed in two of two medication carts (north and south) and medication storage cupboards. In addition, the licensee failed to document all required content of disposition of medications for one of one discharged resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee failed to dispose of expired medications which were located in the north and south medication carts and storage cupboards. On August 30, 2022, at 8:43 a.m. observation of the north side medication cart and medication storage cupboard with unlicensed personnel (ULP)-D identified the following medications were expired: -triple antibiotic ointment, expired November 2018 (used for open skin injury) -miconazole vaginal antifungal, expired December 2021 (used to treat yeast infection) -stock supply of milk of magnesia bottle, expired June 2022 (used for constipation) -L glutamine two bottles, expired January 2021 (used of sickle cell anemia/blood disorder)	01910		

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01910	Continued From page 125 -refresh plus eye drops, expired July 2022 (used for dry eyes) At the time ULP-D stated the ULP were responsible to look for expired medications and were to give the expired medications to the nurse for destruction. On August 30, 2022, at 9:58 a.m. observation of the south side medication cart and medication storage cupboard with ULP-G identified the following medications were expired: -albuterol nebulizer 12 vials, expired July 2021 (relieves muscle tightening in the airways) -one daily vitamin bottle, expired June 2022 (supplement) -ipatropium nebulizer vials (30 vial box), expired July 2022 (works by relaxing and opening the air passages to the lungs) -lisinopril 30 milligram tablets (six total), expired March 31, 2022 (used for high blood pressure) On August 31, 2022, at 10:03 a.m. registered nurse (RN)-C stated, "The person [staff] on the medication cart watches for expired medications and should be doing it daily." RN-C stated the staff "person brings the expired medications to me and I dispose of them." R5 R5 began receiving services on September 23, 2019, and was discharged on April 2, 2022. R5's disposition of medications sheet dated April 20, 2022, indicated medications were sent with family and was signed by RN-C and a witness. The sheet listed the 12 medication names, the strength for seven of the medications and lacked documentation of prescription number and quantity for all twelve medications listed.	01910		

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01910	Continued From page 126 In addition, R5's Medication Administration Record (MAR) dated March 2022, identified R5 was receiving trimethoprim 100 mg one half tablet daily for urinary tract infection and natural vegetable orange powder one tablespoon daily for fiber; however, the medications were not included in the listed medications on R5's disposition of medications sheet dated April 20, 2022. On September 1, 2022, at 11:50 a.m. RN-C verified R5's record lacked the above documented content for disposition of medications upon discharge. The licensee's Discharge Summary policy dated October 11, 2021, indicated a reconciliation of all pre discharge medications with post discharge prescribed and over-the-counter medications would be included in the discharge summary. The licensee's Disposition or Disposal of Medication policy dated January 17, 2022, indicated a client's current medications that are secured or stored by the licensee would be given to the resident or the resident's representative when the resident's medication management services are terminated, except that the conditions listed below must be met before controlled medications belonging to a residents would be given to the resident or the resident's representative. Staff would document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. Disposal of Unused or Discontinued Prescription Drugs Managed by the licensee Colony Court Senior Living Solutions topic indicated Documentation of the destruction,	01910		

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01910	Continued From page 127 listing the date, quantity name of drug, prescription number, signature of person destroying the drugs and signature of witness to the destruction must be recorded and maintained in the client's record for two years. Staff would document the disposition or disposal of medications in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and	01930		

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01930	Continued From page 128 maintain up-to-date written treatment or therapy management policies and procedures. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 29, 2022, at 12:23 p.m., director of nursing (DON)-B confirmed the licensee provided treatment management services. A request was made to review the licensee's policies and procedures. The licensee lacked the following required policies: - monitoring and evaluating the treatment or therapy On September 1, 2022, at approximately 4:24 p.m. DON-B stated the licensee's policy Treatment and Management Plan dated October 21, 2021, indicated the RN would assess the resident every 90 days or as needed based on the treatment/therapy plan that was in place. DON-B verified the policy did not specifically address monitoring and evaluating the treatment or therapy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930		

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01940 SS=E	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: Based on observation, interview and record review, the licensee failed to ensure an individualized treatment or therapy management record to include all required content for two of	01940		

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01940	Continued From page 130 two residents (R1, R2). 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: R1 R1's record lacked an individualized treatment or therapy record to include all content as required for prescribed treatment services of blood sugar checks and continuous positive airway pressure (CPAP). R1's diagnoses included diabetes and sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts). On August 30, 2022, at 6:12 a.m. unlicensed personnel (ULP)-D was observed to assist R1 with continuous positive airway pressure (CPAP) equipment. ULP-D shut of the CPAP machine, removed R1's facial CPAP mask and placed the CPAP facial mask equipment into an enclosed container. ULP-D stated at the time the container was a device that automatically cleansed R1's CPAP facial mask once the mask was placed into the container. At 6:31 a.m. ULP-H stated she worked evenings and night shift and during the shifts, staff assisted R1 with putting on CPAP and blood sugar checks twice weekly.	01940		

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01940	Continued From page 131 R1's Service Plan was signed by licensed assisted living director (LALD)-A on April 27, 2022, and by R1's resident/responsible party on June 21, 2022, indicating R1 received services including support network, activities, case management, financial care management, housekeeping, laundry, manage environment, personal shopping, transportation, bathing, dressing/undressing, eating/meals, mobility, toileting, diabetes management (needs blood sugar checks only), medication administration, medication management (medication set/administration), medication monitoring/admin and reminders, emergency response, general safety, medication management coordination, hearing, abuse risk/vulnerability. R1's record included a prescriber's order dated December 7, 2021, for blood sugar check two times a week. R1's record lacked a prescriber's order for CPAP use. R1's 90-day assessment dated August 8, 2022, indicated "0.4 Medications A. Diabetes Management 4. Needs blood sugar checks only. 7TASK. Tasks for Documentation: Vitals Task: Blood Sugar Twice Weekly Check". The 90 day assessment did not address CPAP use. R1's record identified staff were documenting blood sugar checks twice weekly which included direction from registered nurse (RN)-C of "take blood sugar at 4 p.m. Tuesday and Friday. Please check resident's blood sugar two times a week. If B/S [blood sugar] is below 60 or greater than 450 please notify the PCP [primary care provider] and nursing."	01940		

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01940	Continued From page 132 R1's service plan lacked a written statement of the treatment or therapy services that would be provided to the resident (blood sugar check two times weekly and CPAP) and lacked a current individualized treatment and therapy management record for the treatment services of blood sugar checks and CPAP for the following: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. In addition, R1's service plan lacked the treatment service for CPAP. On August 31, 2022, at 9:17 a.m. licensed assisted living director (LALD)-A stated, "We don't have treatments. I talked to [RN-C] about that yesterday and she said we don't have treatments." On September 1, 2022, at approximately 5:10 p.m. RN-C confirmed R1 utilized a CPAP machine and staff checked R1's blood sugar twice weekly. RN-C confirmed R1's service plan lacked a written statement of the treatment or	01940		

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therapy services as above. RN-C stated the resident assessment would be where content for an individualized treatment or therapy plan record would be documented. RN-C confirmed R1's 90-day assessment lacked addressing a treatment or therapy record for all content as required for the treatment services of blood sugar checks and CPAP.

R2
R2's diagnoses included, but was not limited to, unspecified dementia without behavioral disturbance, hypertension, chronic obstructive pulmonary disease, respiratory failure with oxygen dependence, and unspecified edema.

R2's Service Plan dated August 5, 2022, signed by licensed assisted living director (LALD)-A on August 11, 2022, and by resident/responsible party on August 13, 2022, indicated R2 received services including bathing, toileting, dressing, meal (set up), housekeeping, laundry, transfers, walking standby/supervision, wheelchair mobility, medication management, escorts to meals, case management, hygiene, activities, respiratory equipment, financial/care management, and overnight safety checks.

R2's record identified the following prescriber orders:
-dated August 4, 2022, knee high compression stockings - on in the a.m. and off in p.m.
-dated August 5, 2022, continuous oxygen at two liters via nasal cannula.

On August 30, 2022, at approximately 6:40 a.m. ULP-E was observed to assist R2 with TED stockings and oxygen tubing on and off placement assuring oxygen flow was at proper two liters, stating that R2 "likes her oxygen tubing

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01940	Continued From page 134 off of her face while she is changing clothing." R2's 14-day RN assessment dated August 15, 2022, lacked treatments that included TED stockings and specifics for oxygen treatment services. R2's service plan lacked a written statement of the treatment or therapy services that would be provided to the resident (TED stockings, oxygen) and R2's record lacked a current individualized treatment and therapy management record for the treatment services of TED stocking and oxygen for the following: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. In addition, the service plan did not include TED stockings and lacked description of oxygen equipment services further than changing tubing. On September 1, 2022, at approximately 6:20 p.m. RN-C confirmed that R2's record lacked a treatment plan.	01940		

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(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 135 The licensee's Treatment Management Plan policy dated October 21, 2021, indicated the licensee would provide treatment/therapy management services only after a face-to-face assessment has been performed by our Registered Nurse. The treatment or therapy services would be recorded on the TAR/task. The RN would identify what treatment and therapies will be delegated to the unlicensed staff and train them on the treatment and therapy prior to having them perform the treatment/therapy. The nurse would document any specific instruction related to the treatment and therapy administration on the record for the staff to view. The nurse would have a procedure for when to notify the nurse and a procedure of notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health	01950		

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	28411	A. BUILDING: _____ B. WING _____	09/01/2022

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professional has:
(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;
(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and
(3) communicated with the unlicensed personnel about the individual needs of the resident.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records for two of two residents (R1, R2) receiving treatments and had instructed the unlicensed personnel in the proper methods with respect to each resident and two of two unlicensed personnel (ULP-D, ULP-E) has demonstrated the ability to competently follow the procedures.

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:

R1

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01950	Continued From page 137 R1's record lacked specific instructions for the delegated treatment service of continuous positive airway pressure (CPAP). R1's diagnoses included sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts). On August 30, 2022, at 6:12 a.m. unlicensed personnel (ULP)-D was observed to assist R1 with CPAP equipment. ULP-D shut of the CPAP machine, removed R1's facial CPAP mask and placed the CPAP facial mask equipment into an enclosed container. ULP-D stated at the time the container was a device that automatically cleansed R1's CPAP facial mask once the mask was placed into the container. At 6:31 a.m. ULP-H stated she worked evenings and night shift, and during the shifts staff assisted R1 with putting on CPAP. On August 30, 2022, at 10:28 a.m. R1 stated, "Yep" the staff helped with his CPAP. R1 stated the staff "check the water and add distilled water and help get on and take off." R1's Service Plan signed by licensed assisted living director (LALD)-A on April 27, 2022, and by R1's resident/responsible party on June 21, 2022, lacked the treatment service for CPAP. R1's Task sheet dated August 2022, lacked documentation of staff providing the treatment service of CPAP. ULP TRAINING AND DEMONSTRATED COMPETENCY ULP-D had a hire date of December 19, 2011, and lacked training and skills competency for	01950		

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01950	Continued From page 138 CPAP. ULP-E had a hire date of June 22, 2022. ULP-E's record identified Educare (computer training program) training dated July 6, 2022, for "Medication and Treatment CPAP" and "CPAP Skills Validation" dated July 12, 2022; however, the training and competency was not specific to R1's treatment service of CPAP. ULP-D and ULP-E's records lacked training and demonstrated competency for providing the treatment service of R1's CPAP. On September 1, 2022, at approximately 11:11 a.m. RN-C confirmed ULP-D and ULP-E's records lacked documented evidence of training and competency specific to providing R1's treatment service of CPAP. On September 1, 2022, at approximately 5:10 p.m. RN-C confirmed R1 utilized a CPAP machine, and lacked specific instructions for the treatment service of CPAP. R2 R2's diagnoses included, but was not limited to, unspecified dementia without behavioral disturbance, hypertension, chronic obstructive pulmonary disease, respiratory failure with oxygen dependence, and unspecified edema. R2's Service Plan last review date of August 5, 2022, was signed by licensed assisted living director (LALD)-A on August 11, 2022, and by resident/responsible party on August 13, 2022, indicated R2 received services including bathing, toileting, dressing, meal (set up), housekeeping,	01950		

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01950	Continued From page 139	01950		

laundry, transfers, walking standby/supervision, wheelchair mobility, medication management, escorts to meals, case management, hygiene, activities, respiratory equipment, financial/care management, and overnight safety checks. The service plan did not identify R2 received assistance with treatment service of oxygen.

On August 30, 2022, at approximately 6:40 a.m. ULP-E was observed to assist R2 with oxygen tubing on and off placement and assuring oxygen flow was at proper two liters stating R2 "likes her oxygen tubing off of her face while she is changing clothing."

R2's prescriber's orders dated August 5, 2022, indicated continuous oxygen at two liters per minute via nasal cannula.

R2's Task sheet dated August 2022, identified staff were signing for providing the services of "oxygen tubing", but lacked specific instructions for the evidence of documentation for flow rate and tubing changes.

On September 1, 2022, at approximately 6:00 p.m. RN-C confirmed the Oxygen flow rate was not in R2's record for ULP to reference and lacked instruction for changing the oxygen tubing.

The licensee's Administration of Medication, Treatment and Therapy by unlicensed Personnel policy dated October 6, 2021, indicated the RN may delegate to unlicensed personnel the task of providing assistance with self-administration of medications or may delegate administration of medications, treatment, and therapy if the unlicensed personnel have satisfied the training requirements listed above if: Before performing the procedures, the RN had instructed the

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01950	Continued From page 140 unlicensed personnel in the proper methods to administer the medications, treatment and therapy and the unlicensed personnel have demonstrated the ability to competently follow the procedures; The RN had developed written, specific instruction for each resident; The RN had documented that the unlicensed personnel have been trained and have demonstrated competency to follow the procedures. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment services were documented for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01960		

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01960	Continued From page 141 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: R1 R1's diagnoses included sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts). On August 30, 2022, at 6:12 a.m. unlicensed personnel (ULP)-D was observed to assist R1 with continuous positive airway pressure (CPAP) equipment. ULP-D shut of the CPAP machine, removed R1's facial CPAP mask and placed the CPAP facial mask equipment into an enclosed container. ULP-D stated the container was a device that automatically cleansed R1's CPAP facial mask once the mask was placed inside. At 6:31 a.m. ULP-H stated she worked evenings and night shift, and during the shifts staff assisted R1 with putting on CPAP. R1's Service Plan signed by licensed assisted living director (LALD)-A on April 27, 2022, and by R1's resident/responsible party on June 21, 2022, indicated R1 received services including support network, activities, case management, financial care management, housekeeping, laundry, manage environment, personal shopping, transportation, bathing, dressing/undressing, eating/meals, mobility, toileting, diabetes management (needs blood sugar checks only), medication administration, medication	01960		

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management (medication set/administration), medication monitoring/admin and reminders, emergency response, general safety, medication management coordination, hearing, abuse risk/vulnerability. R1's service plan lacked the treatment service for CPAP.

R1's Task sheet dated August 2022, lacked documentation of staff providing the treatment service of CPAP.

R1's record lacked documentation of staff providing the treatment service of CPAP.

On September 1, 2022, at approximately 5:10 p.m. RN-C confirmed R1 record lacked documentation of staff providing the treatment service of CPAP.

R2
R2's record lacked documentation for time of administration for treatment of oxygen and TED stockings (compression stockings used for swelling) and lacked accurate documentation for oxygen saturation levels (amount of oxygen in blood).

R2's diagnoses included unspecified dementia without behavioral disturbance, hypertension, chronic obstructive pulmonary disease, respiratory failure with oxygen dependence, and unspecified edema.

R2's Service Plan dated August 5, 2022, signed by LALD-A on August 11, 2022, and by resident/responsible party on August 13, 2022, indicated R2 received services including bathing, toileting, dressing, meal (set up), housekeeping, laundry, transfers, walking standby/supervision, wheelchair mobility, medication management,

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01960	Continued From page 143	01960		

escorts to meals, case management, hygiene, activities, respiratory equipment, financial/care management, and overnight safety checks. The service plan did not identify R2 received assistance with treatments service of TED (thrombo embolic deterrent) stockings (compression stockings used to increase circulation and reduce swelling) and lacked a description of oxygen equipment services further than changing tubing.

R2's prescriber's orders dated August 5, 2022, indicated oxygen continuous at two liters per minute via nasal cannula, and TED stockings order dated August 4, 2022, indicating knee high compression stockings on in the a.m. and off in p.m.

On August 30, 2022, at approximately 6:40 a.m. ULP-E was observed to assist R2 with TED stockings, oxygen tubing on and off placement and assuring oxygen flow was at two liters stating R2 "likes her oxygen tubing off of her face while she is changing clothing."

R2's Task sheet dated August 2022, lacked documentation for the treatment services of oxygen (flow rate) and TED stockings (on/off times).

Review of R2's weights and vital signs summary for oxygen saturation monitoring from August 17, 2022, through September 1, 2022, indicated that staff were documenting R2's oxygen saturation levels on "room air" when R2 was actually receiving oxygen at two liters per minute. R2's weights and vital signs summary for oxygen saturation monitoring lacked accurate information regarding oxygen treatment.

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01960	Continued From page 144 On September 1, 2022, at approximately 6:20 p.m. RN-C confirmed R2's record lacked documented evidence of oxygen flow rate and instruction for oxygen tubing change. RN-C confirmed the vital signs summary for oxygen saturation should have indicated that R2 was receiving oxygen at two liters per minute, and she would follow up with ULP to ensure proper documentation with oxygen flow. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated October 4, 2021, indicated the RN would document the services the resident would receive on the resident's individualized medication management plan and individualized treatment and therapy plan and client's medication/treatment record or MAR/TAR. Staff would document each task immediately after that task has been performed. Documentation would follow professional standards for documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.	01970		

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01970	Continued From page 145 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a prescriber's order for treatment or therapy for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1's diagnoses included sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts). On August 30, 2022, at 6:12 a.m. unlicensed personnel (ULP)-D was observed to assist R1 with continuous positive airway pressure (CPAP) equipment. ULP-D shut of the CPAP machine, removed R1's facial CPAP mask and placed the CPAP facial mask equipment into an enclosed container. ULP-D stated the container was a device that automatically cleansed R1's CPAP facial mask once the mask was placed inside. At 6:31 a.m., ULP-H stated she worked evenings and night shift, and during the shifts staff assisted R1 with putting on CPAP. R1's Service Plan signed by licensed assisted living director (LALD)-A on April 27, 2022, and by R1's resident/responsible party on June 21, 2022,	01970		

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01970	Continued From page 146 indicated R1 received services including support network, activities, case management, financial care management, housekeeping, laundry, manage environment, personal shopping, transportation, bathing, dressing/undressing, eating/meals, mobility, toileting, diabetes management (needs blood sugar checks only), medication administration, medication management (medication set/administration), medication monitoring/admin and reminders, emergency response, general safety, medication management coordination, hearing, abuse risk/vulnerability. R1's service plan lacked the treatment service for CPAP. R1's Task sheet dated August 2022, lacked documentation of staff providing the treatment service of CPAP. R1's record lacked documented evidence of a prescriber's order for the treatment service of CPAP. On September 1, 2022, at approximately 5:10 p.m. registered nurse (RN)-C confirmed R1 record lacked documented evidence of a prescriber's order for the treatment service of CPAP. The licensee's Treatment Management Plan policy dated October 21, 2021, indicated the RN would obtain orders for treatment/therapies for services provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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02110	Continued From page 147	02110		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.	02110		

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02110	Continued From page 148 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care and failed to provide the policies and procedures to residents and the residents' legal and designated representatives at the time of move-in. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2022. The licensee lacked the following policies and procedures related to dementia care: - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; and - limiting the use of public address and intercom systems for emergencies and evacuation drills only. On September 1, 2022, at approximately 4:24 p.m. director of nursing (DON)-B confirmed the licensee lacked a policy to address psychotropic medications. DON-B and licensed assisted living director (LALD)-A stated "we don't have an	02110		

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02110	Continued From page 149 intercom system in the facility." LALD-A stated she would be the person to provide the policies and procedures to residents and the residents' legal and designated representatives at the time of move-in and it would be "in the official paper work". LALD-A stated, "I don't think there is anything in there" regarding providing the policies and procedures. No further information was provided TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a	02140		

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02140	Continued From page 150	02140		

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 August 29, 2022, at approximately 12:23 p.m. registered nurse (RN)-C stated she oversaw training staff in the care of individuals with dementia.

RN-C's record included training through Educare (electronic training program) for dementia care topics with a total of 10.75 hours.

On September 1, 2022, at 12:20 p.m. licensed assisted living director (LALD)-A stated RN-C "needs to take further education through Educare" to obtain certificate or current competency/knowledge test for dementia training. LALD-A stated she had reached out to the "owner" of Educare by email to inquire if RN-C had the needed training through Educare to meet the requirements. The email provided by LALD-A dated September 1, 2022, indicated "take the Dementia Series-AA [Alzheimer's Association] recognized-BELTSS [Board of Executives for Long Term Services and Supports] and complete exams. This series is approved as well as the test by MDH [Minnesota Department of Health] and the commissioner for this purpose". LALD-A confirmed RN-C's record lacked the training.

The licensee's Assisted Living and Assisted Living with Memory Care Dementia Training policy dated October 8, 2021, indicated assisted living staff would receive required training on dementia care during orientation and annually. Supervisor Requirements: persons providing or overseeing

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02140	Continued From page 151 staff training must have experience and knowledge in the care of individuals with dementia including: Two years of work experience related to Alzheimer's disease or other dementias or in health care, gerontology, or another related field; Completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		
02170 SS=E	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not	02170		

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02170	Continued From page 152 limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure evaluation for activities and an individualized activity plan was developed for two of two residents (R1, R2). 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: R1 R1's 90-day assessment dated August 2, 2022, indicated for activity capabilities R1 needed daily reminders to attend wellness activities and was poorly motivated to participate in activities.	02170		

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02170	Continued From page 153 Resident would come out for music when we have entertainment. Resident would receive assistance with activities and be encouraged to participate in activities. On August 30, 2022, at 10:28 a.m. R1 stated, "there isn't any available here. I have to go to the other building across the highway [owned by same licensee] for activities. They don't have no activity person, they used to have one." R1 stated, "I like to play cards with people. I don't get any of that here. They finally agreed to let me go to the other place across the road." R1's Progress Note dated July 12, 2022, documented by licensed assisted living director (LALD)-A indicated the licensee spoke with R1's responsible party and "discussed having him come over here [another building] for activities once in a while to get him out of the MC [memory care] building. So we are going to try that for a bit and see if that helps his socialization." R1's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests; - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions In addition, R1's record lacked an individualized activity plan developed based on an activity evaluation, which reflected the R1's activity preferences and needs, including a selection of	02170		

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02170	Continued From page 154 daily structured and non-structured activities being provided and included on R1's activity service or care plan. R2 R2's diagnoses included unspecified dementia without behaviors, hypertension, chronic obstructive pulmonary disease, respiratory failure with oxygen dependence, and osteoarthritis. R2's 14-day assessment dated August 15, 2022, indicated for activity capabilities, R2 was independent-participates in wellness activities of choice without help. and Needs curing (remind and encourage to participate in wellness activities). Resident would receive assistance with activities and be encouraged to participate in activities. R2's 14-day assessment did indicate favorite wellness activities that included crossword puzzles and puzzles. R2's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions In addition, R2's record lacked the development of an individualized activity plan or a selection of daily structured and non-structured activities that were based on resident's evaluation. R2's service plan dated August 3, 2022, indicated "will encourage resident to participate in	02170		

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02170	Continued From page 155 activities." On August 29, 2022, at 12:23 p.m. during the entrance conference, LALD-A stated the facility lost the staff person who was the activity assistant for resident daily activities. LALD-A stated the facility planned a one time a week community activity, one time a week church service, staff interact with residents with music, painting nails, games, taking outside, read paper, and when nursing students were in the facility they engaged with the residents. On September 1, 2022, at approximately 5:10 p.m. LALD-A stated, "No" regarding there being activity evaluations and individualized activity plans developed for R1 and R2. The licensee's Description of Life Enrichment Programs and How Activities are Implemented In ALDC (assisted living with dementia care) policy dated October 25, 2021, indicated it was the licensee's policy to provide a selection of daily activities based on individual and group interests. Individual and group activities would be planned, as well as structured and non-structured activities. Opportunities for outdoor time and for engagement with the broader community will be facilitated for those interested. Each resident receiving assisted living services would be evaluated for activities. The evaluation would include the required content according to assisted living statute 144G.82. To further facilitate person-centered care, social history information, information about the person's life history, would be gathered to assist in planning. An individualized activity plan would be developed for those receiving assisted living services based on their activity evaluation. The plan would reflect the resident's activity	02170		

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02170	Continued From page 156 preferences and needs. A selection of daily structured and non-structured activities would be provided and included on the resident's activity service or care plan as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include a description of the training program for dementia care in written or electronic form to residents, families, or other persons who request it, with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	02260		

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02260	Continued From page 157 The findings include: The licensee's Disclosure of Special Care addressed related training it provides for dementia care, including the categories of employees trained, the frequency of training, and the basic topics covered; however, the disclosure lacked a description of the training program (how the training was provided). On September 1, 2022, at 9:33 a.m. licensed assisted living director (LALD)-A reviewed the licensee's disclosure for reference of the licensee's description of the training program. LALD-A stated, "It doesn't say that." LALD-A sated the licensee utilized Educare (an electronic training program) for training of topics for dementia care. The licensee's Assisted Living and Assisted Living with Memory Care Dementia Training policy dated October 8, 2021, indicated a description of the training program, categories of employees trained, the frequency of training, and basic topics covered with be provided to consumers in writing or electronic form to residents and families or other persons who request it. A hard copy will be made available upon request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02260		
02430 SS=F	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of	02430		

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02430	Continued From page 158	02430		

information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party.
(b) Residents have the right to access their own records.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private. This has the potential to affect all 17 residents residing at the facility.

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

The findings include:

On August 29, 2022, at approximately 11:49 a.m. observation of the north side and south side staff desks located in the dining room area and accessible to any persons identified binders labeled "POLST" (physician orders for life sustaining treatment), "Individual Service Plan" and "RTask procedures" were located at the staff desks and were accessible to any persons.

On September 1, 2022, at 11:40 a.m. observation of the north and south side staff desks with

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02430	Continued From page 159 director of nursing (DON)-B and registered nurse (RN)-C identified resident information (POLST, care plans, etc.) were accessible to any persons located in binders on top of the desks and in unlocked drawers of the desks. The licensee's Security of Resident Records policy dated October 18, 2021, indicated resident records would be kept secure and protected against loss, tampering or unauthorized disclosure. All information in the resident record must be kept confidential and accessible only to authorized agency personnel. No further information provided. TIME PERIOD FOR CORRECTION: TWENTY-ONE (21) DAYS	02430		
03000 SS=H	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined	03000		

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03000	Continued From page 160 in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected abuse; failed to notify emergency contact of resident to resident sexual abuse and failed to complete a thorough investigation for occurrences of suspected abuse	03000		

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03000	Continued From page 161 for five of five residents (R14, R15, R6, R17, R16). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R14/R15 R14's diagnoses included dementia (memory loss) likely multifactorial in etiology with resulting behavioral disturbance. R14's MAARC report submitted Friday, February 11, 2022, at 12:47 p.m., indicated "Description of Incident", on February 10, 2022, at 7:30 a.m. staff reported resident was found in the dining area with only his underwear on. R14 had pulled out his penis and was holding it in his hand and waving in a female peer's face (R15). R14 was saying "come on baby touch it." Resident (R15) was upset and telling R14 "no, get away." Staff intervened and took R14 back to room and assisted getting R14 dressed. R14's service plan initiated February 10, 2022, indicated sexually inappropriate behavior. Responds to redirection. Staff will monitor resident throughout the day and night. Doors to resident's room will be locked by 8 pm. A door alarm was be added to resident's room, so staff are aware when R14 comes out.	03000		

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R15's diagnoses included Alzheimer's disease (memory loss) and anxiety.

R15's MAARC report submitted Thursday, February 17, 2022, at 13:24 (1:24 p.m.) indicated "Description of Incident", on February 10, 2022, at 7:30 a.m. the same information as above on R14's MAARC report, and indicated R15 remains very scared of R14. R14 was sent to the emergency room (ER) and the provider note stated if R14 "gets another erection, put [R14] in a cool shower, if [R14] continues to be inappropriate, put [R14] on a one (1) to one (1) with sitter. We are not staffed to offer that and the facility does not offer that. The bedroom doors are shut by 8 p.m. Door sensor was placed on [R14's] door."

On August 31, 2022, at 11:56 a.m. registered nurse (RN)-C verified the time the incident was reported. RN-C stated she had talked to R15, and R15 "was ok" and she had talked to R14, but R14 "denied it all." RN-C stated family was notified and staff were informed of new behavior interventions. RN-C stated there was no documentation of staff interviews conducted beyond information documented in the MAARC report to determine if any other resident to resident sexual abuse incidents had occurred. RN-C stated she had not interviewed other residents to determine if other resident to resident sexual abuse had occurred.

R6/R14
R6's diagnoses included Alzheimer's disease (memory loss).

A MAARC report submitted Monday, April 4,

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2022, at 11:18 a.m. indicated "Description of Incident," on April 1, 2022, at 5:00 p.m. R14's door alarm went off and R14 had come out of his room and was wandering the facility. At 8:00 p.m. unlicensed personnel (ULP)-M had seen R14 come out of R6's room. At 9:00 p.m. ULP-H was giving R6 a shower and had inquired to R6 "if there was a man in her room earlier." R6 stated, "Yes, he was trying to get fresh with me. He was trying to get me to play with his penis, but I said NO and then he was trying to insert it into me." R6 stated R14 "told her it would make her feel better."

A MAARC report submitted Friday, May 27, 2022, at 12:50 p.m. indicated "Description of Incident", on May 26, 2022, at 3:45 p.m. R14 was seen by staff to be coming out of R6's room. R16 reported to staff "oh he just likes to massage my breasts, that's all."

On August 31, 2022, at 11:56 a.m. RN-C stated the resident to resident sexual abuse incident which occurred on April 1, 2022, was not reported until April 4, 2022, due to "weekend staff didn't think it was important." RN-C stated, "Some education on that, reporting immediately" was done with staff. RN-C stated if she had known about it right away, she would have "called police and had a test kit, rape kit done, but they [staff] didn't report until Monday." RN-C stated, "I usually report right away as soon as I know about it." RN-C stated staff were educated regarding what need to be reported, but there was no documentation of the education provided. RN-C stated she had talked to R6 and R14 and the interview should be in the resident records. RN-C stated staff interviews were not conducted beyond information documented in the MAARC reports and resident records to determine if other

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	28411	A. BUILDING: _____ B. WING _____	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY COURT MEMORY CARE	500 22ND AVENUE NW WASECA, MN 56093

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03000	Continued From page 164	03000		

resident to resident sexual abuse had occurred. RN-C stated no other residents were interviewed to determine if other resident to resident sexual abuse had occurred. At that time, licensed assisted living director (LALD)-A and director of nursing (DON)-B stated, "No" the licensee had not notified R6's family regarding the resident to resident sexual contact. LALD-A and DON-B stated the Ombudsman had informed "not to tell [R6's] family." LALD-A and DON-B stated the Ombudsman had stated "this is to be expected in memory care. Very common behavior in memory care" and "notifying [R6's] family would be a violation of privacy for [R14]."

The licensee failed to immediately report a resident to resident sexual abuse incident to MARRC, failed to inform R6's emergency contact person #1 (family member) of resident to resident sexual abuse incidents involving R6, and lacked evidence of a thorough investigation of the incident.

R17
R17's diagnoses included dementia (memory loss).

R17's service plan initiated April 28, 2022, indicated no known injuries, no pain reported, needs occasional supervision/standby help and supervision to walk, uses walker for mobility and resident will have a chair alarm as she sleeps in a recliner.

A Facility Bulletin (posted on the facility computer system) indicated R17 had moved in this afternoon, has "had a lot of falls, so for now please do an assist of one with transfers. She is supposed to be able to walk independent but needs her walker at all times. She sleeps in a

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	28411	A. BUILDING: _____ B. WING _____	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY COURT MEMORY CARE	500 22ND AVENUE NW WASECA, MN 56093

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03000	Continued From page 165	03000		

recliner. She has two chair sensors as she sleeps in her recliner. Let's just do an assist of one for now please until we get some more info [information]."

A MAARC report submitted Monday, May 2, 2022, at 13:33 (1:33 p.m.), indicated "Description of Incident," on April 30, 2022, when R17's family came to the facility resident was lethargic and unable to sip from a straw or respond to conversation. There were no reports of fall or resident complaining of pain throughout the night. When staff tried to get resident up in the morning, she required a lift to get up and into chair. "Family took resident to hospital via ambulance." Writer was notified today that resident has a broken right hip requiring surgery. The report further indicated resident was admitted to the facility on "April 28th" at 4:00 p.m. due to many falls. Resident had four falls from April 21 to April 24. Resident had a large bruise on right hip upon admission. Family had taken resident to a doctor appointment on Friday (April 29) where it was found that R17 had a urinary tract infection (UTI).

On August 31, 2022, at 11:56 a.m. LALD-A stated there was no incident report for the above incident. RN-C stated she was informed R17 was taken to the hospital over the weekend but did not know R17 had a fractured hip until Monday morning when the family informed her. RN-C stated she had not interviewed R17's family to inquire if R17 had any incidents when R17's family had taken R17 to the doctor appointment on Friday April 29, 2022. RN-C stated she had no documentation of staff interviews since R17 was admitted determining if abuse/neglect occurred related to the diagnosis of right hip fracture. RN-C stated she had asked staff if R17 "had fallen or if they had noticed anything strange" with R17. Staff

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	28411	A. BUILDING: _____ B. WING _____	09/01/2022

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03000	Continued From page 166	03000		

reported R17 was "tired" and was "sleeping in chair". RN-C stated she had not documented the information. RN-C stated R17 walked independent upon admission and had no complaints of pain.

The licensee lacked documented evidence of employee interviews since admission due to the diagnosis of right hip fracture two days after admission to determine if abuse/neglect occurred.

R16
R16's diagnoses included dementia (memory loss) without behavioral disturbance, diabetes (condition that affects the way the body processes blood sugar) and age related osteoporosis (condition in which bones become weak and brittle) without current pathological fracture.

R16's Progress note dated August 14, 2022, indicated RN-F had "received phone call from facility" resident had fallen and family had questions about resident's return.

A MAARC report submitted Monday, August 15, 2022, at 11:47 a.m., indicated "Description of Incident", on the evening of August 13, 2022, staff heard a noise and resident began to yell. Staff found resident on the floor. "Resident stated she was reaching for something on her couch. Resident has dementia so she did not give much more of an explanation." Staff called for assistance from emergency medical service (EMS). When EMS arrived resident began complaining of right hip pain. Resident was taken to hospital where it was determined resident had a broken right hip. Resident had surgery on

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY COURT MEMORY CARE	500 22ND AVENUE NW WASECA, MN 56093

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03000	Continued From page 167 August 14, 2022, to repair right hip. Action taken indicated resident chair alarm is in place for when resident returns as well as a bed alarm. The licensee failed to immediately report to MAARC of an unwitnessed fall with injury (right hip fracture) and lacked evidence of a thorough investigation to determine if abuse/neglect occurred. On August 31, 2022, at 11:56 a.m. RN-C stated the reason for delay of reporting was the incident occurred on a Saturday and she had not reported until on Monday. RN-C verified there was no evidence of a thorough investigation to determine if abuse/neglect occurred. The licensee's Vulnerable Adult Maltreatment Policy dated October 11, 2021, indicated for reporting maltreatment any staff person who witnesses or suspects maltreatment of a vulnerable adult (VA) would immediately report the incident to their assisted living director and that person would complete an incident report. If the incident appears to be suspected abuse, neglect, or financial exploitation, assisted living director/regional nurse would immediately make a report to the CEP (common entry point). MAARC website was indicated on the policy. "Immediately" means as soon as possible, but no longer than 24 hours from the time the assisted living director/registered nurse received initial knowledge that the incident occurred. If it appears at any time a crime may have been committed , assisted living director/regional nurse would immediately contact the police if the witness had not already done so. Internal Investigation: staff would complete an incident report. The DNS, LALD, or designee would complete an internal investigation pertaining to the report of potential	03000		

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03000	Continued From page 168 or suspected maltreatment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

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

Type: Full
Date: *08/30/22*
Time: 08:20:06
Report: 8044221285

Food and Beverage Establishment Inspection Report

Location:
Colony Court Memory Care - South Kitchen
500 22nd Avenue Nw
Waseca, MN56093
Waseca County, 81

Establishment Info:
ID #: 0038022
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5078376100
ID #:

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

The following orders were issued during this inspection.

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

No sign in entrance rest room.

Comply By: 08/31/22

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 36.9 Degrees Fahrenheit - Location: Milk in upright
Violation Issued: No

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

HRD inspection conducted with team lead Danette Bakken.

Inspection report reviewed with housing manager, Tammy.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044221285 of 08/30/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
Inspector signed for Tammy

Signed:_____
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us