Electronically Delivered

May 15, 2023

Licensee
Abilit Holdings Prairie Meadows
800 5th Avenue Northwest
Kasson, MN 55944

RE: Project Number(s) SL24053015

Dear Licensee:

On May 3, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 4, 2022. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 4, 2022 survey.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on November 4, 2022, found not corrected at the time of the May 3, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0510-Infection Control Program-144g.41 Subd. 3 - $500.00
0730-Contents Of Resident Record-144g.43 Subd. 3
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E)
2180-Services For Residents With Dementia-144g.84

The details of the violations noted at the time of this follow-up survey completed on May 3, 2023 (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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans

of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

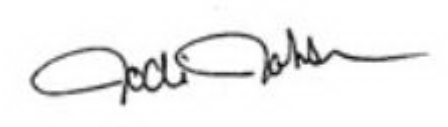
REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.
We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24053	A. BUILDING: _____ B. WING _____	R 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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 SL24053015 On May 1, 2023, through May 3, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 4, 2022, and February 2, 2023. At the time of the survey, there were 47 residents: 37 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.	
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	{0 510}		

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{0 510}	Continued From page 1	{0 510}		

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 ensure infection control standards were followed for one of one unlicensed personnel (ULP-DD) during medication administration for R1 and R11.

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

The findings include:

On May 2, 2023, at 7:10 a.m. the surveyor observed ULP-DD in R1's apartment as she prepared to complete a blood glucose (blood sugar) check for R1. ULP-DD gathered supplies (glucometer, test strip, lancet used to poke the finger to obtain a drop of blood, an alcohol wipe), and donned gloves. ULP-DD completed R1's blood glucose check and with the same gloves, ULP-DD entered the blood glucose results on the

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{0 510}	Continued From page 2	{0 510}		

tablet (used for documentation). Then, ULP-DD gathered the supplies used, disposed of the glucose test strip and lancet into the sharps container, unlocked the medication cabinet door, put away the glucometer, pulled out R1's medication bucket and then removed her gloves, used hand sanitizer, and donned clean gloves. While ULP-DD set up R1's medications, the surveyor observed one tablet fall to the ground. ULP-DD picked up the tablet and asked R1 if she could still use it. R1 stated it was fine with her. ULP-DD placed the tablet into the medication cup and administered to R1. ULP-DD was then observed to document the medication administration and assisted R1 with her compression stockings. ULP-DD then, without using it, picked up a bottle of hand sanitizer, put it in her pocket and went to the memory care unit.

On May 2, 2023, at 8:00 a.m. ULP-DD was observed to open the door to the memory care unit, went to the medication cart, opened it, put on gloves, opened her tablet and set up medications for R11. With the same gloves, ULP-DD locked the medication cart and headed to R11's room. On the way to R11's room, ULP-DD observed R4 in her room rolled to the edge of her bed. ULP-DD quickly entered the room, set R11's medications down and assisted R4 with repositioning. ULP-DD then exited the room with R11's medications and entered R11's room. With the same gloves, ULP-DD administered R11's oral medications and applied topical cream to the area under R11's breasts. Then, ULP-DD removed her gloves and used hand sanitizer. ULP-DD failed to properly remove her gloves, wash or sanitize her hands after touching multiple surfaces with medication set up and administration and between contact with residents.

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{0 510}	Continued From page 3 The licensee's Glove policy dated August 1, 2021, indicated gloves must be worn whenever there may be direct contact between an employee and contaminated objects. Following the removal or contact with a contaminated material, dispose of used gloves in the proper receptacle, and rewash hands. The licensee's Handwashing policy dated August 1, 2021 indicated Hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contaminations. When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. No further information was provided.	{0 510}		
{0 730} SS=E	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;	{0 730}		

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{0 730}	Continued From page 4 (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 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 six of six resident records (R1, R2, R3, R4, R8, R11) included documentation of services provided. This practice resulted in a level two violation (a violation that did not harm a resident's health or	{0 730}		

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{0 730}	Continued From page 5 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 dated March 23, 2023, included the services of TED (thrombo-embolic deterrent) stocking (used to prevent blood clots in the lower extremities) assistance, medication administration, blood glucose checks, safety checks, and housekeeping tasks. R1's Documentation Survey Report v2 (task documentation record) dated April 2023, lacked consistent documentation of tasks completed to include: -Behavior monitoring; -orientation to the service/plan, individual abuse prevention plan; and -visual checks once per shift R2 R2's Service Plan dated March 16, 2023, included the services of medication administration, hourly visual checks with a known fall risk/history of falls, bathing, assistance with toileting, grooming, dressing, oral hygiene, and various housekeeping tasks. Additionally, R2 received services in the licensee's memory care unit. R2's Documentation Survey Report v2 dated April 2023, lacked consistent documentation of tasks	{0 730}		

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{0 730}	Continued From page 6	{0 730}		

completed to include:
-behavior redirection;
- COVID-19 screening;
-housekeeping;
-orientation to the service plan/tasks that need to perform on my shift, the vulnerable adult abuse prevention plan and resident needs;
-trash removal;
-toileting assistance every four hours; and
-visual checks eight times per shift

R3
R3's Service Plan dated March 21, 2023, included the services of medication administration, bathing, dressing, grooming, compression wraps, urinary catheter care, weights/vital signs as ordered, skin monitoring with wound care provided by a home health agency, transfer assistance as needed, safety checks with a known fall risk, and various housekeeping tasks.

R3's Documentation Survey Report v2 dated April 2023, lacked consistent documentation of tasks completed to include:
-hydrocolloid dressing (specialized wound dressing) to L (left) foot (staff to ensure dressing is intact) each shift;
-orientation to the service plan/tasks that need to perform on my shift, the vulnerable adult abuse prevention plan and resident needs;
-as needed EZ stand (mechanical lift) use for transfers to reduce friction to skin;
-toileting assistance; and
-visual checks once per shift

R4
R4's Service Plan dated March 15, 2023, included the services of medication administration, bathing, dressing, toileting, safety

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{0 730}	Continued From page 7 checks with a known fall risk/history of falls, and various housekeeping tasks. Additionally, R4 received services in the licensee's memory care unit. R4's Documentation Survey Report v2 dated April 2023, lacked consistent documentation of tasks completed to include: -COVID-19 Screening; -dressing/undressing hands on assistance; -hygiene/grooming assistance; -assistance with R4 to socialize or engage in an activity; -oral care assistance; -orientation to the service plan/tasks that need to perform on my shift, the vulnerable adult abuse prevention plan and resident needs; -assistance with eye glasses; -toileting assistance; and -visual checks eight times per shift R8 R8's Service Plan dated March 17, 2023, included the services of medication administration, wound care (for active pressure wound on right hip, provided by home care agency), skin monitoring and repositioning reminders/assistance, toileting, bathing, grooming, dressing/undressing, assistance with transfers, safety checks with a known fall risk/history of falls, weights/vital signs as ordered, and various housekeeping tasks. Additionally, R8 received services in the licensee's memory care unit. R8's Documentation Survey Report v2 dated April 2023, lacked consistent documentation of tasks completed to include: -assist of one with all transfers/pivot transfers; -monthly call pendant check;	{0 730}		

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{0 730}	Continued From page 8 -COVID-19 Screening; -bathing/shower assistance; -dressing/undressing assistance; -orientation to the service plan/tasks that need to perform on my shift, the vulnerable adult abuse prevention plan and resident needs; -skin integrity: encourage and assist resident to lay on his back or left hip to offload the right hip (has an active pressure ulcer); - weekly weights; -pericare (cleansing of the private area), disposal of incontinence products, assist of one staff; -toileting every two hours; and -visual checks eight times each shift R11 R11's Service Plan dated May 1, 2023, included medication administration, bathing, assistance with CPAP (continuous positive airway pressure machine to assist with sleep apnea), TED stockings assistance, and safety checks with a known fall risk/history of falls. Additionally, R11 received services in the licensee's memory care unit. R2's Documentation Survey Report v2 dated April 2023, lacked consistent documentation of tasks completed to include: -activity reminders; -COVID 19 screening; -encourage extra fluids at meals and snack times; -ensure resident is wearing shoes or grippy socks when not in bed; -hearing aides assistance in/out; -stand by assistance with transfers and ambulation; -orientation to the service plan/tasks that need to perform on my shift, the vulnerable adult abuse prevention plan and resident needs;	{0 730}		

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{0 730}	Continued From page 9 -incontinence assistance, assist resident to the bathroom, observe groin area and apply cream as directed/ordered. (resident had a recurring rash to groin); -pericare, disposal of incontinence products-assist of one staff; and -visual checks eight times per shift On May 2, 2023, at 9:00 a.m. regional nurse specialist (RNS)-E stated she had noticed this already with printing out the information for the surveyor and the leadership team had already started the disciplinary process with the staff involved. The licensee's Resident Record-Documentation (2.25) dated August 1, 2021, indicated staff authorized to document in a resident record would do so for all medications, services, treatments, and therapies for each resident. Staff would also document other important and pertinent information related to each resident. When medications, services, treatment, or therapies are not performed per the service agreement and schedule, staff must document the reason why it was not performed or administered. No further information was provided.	{0 730}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	{0 800}		

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{0 800}	Continued From page 10 repair program. This MN Requirement is not met as evidenced by: No further action needed.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar 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	{0 810}		

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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
{0 810}	Continued From page 11 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}		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in 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:	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24053	A. BUILDING: _____ B. WING _____	R 05/03/2023

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ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

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{01620}	Continued From page 12	{01620}		

Based on observation, interview, and record review, the licensee failed to conduct a comprehensive reassessment with a change of condition and failed to complete ongoing assessments of a wound for one of one resident (R11).

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:

R11's diagnoses included Alzheimer's disease (changes in the brain affecting memory, thinking, behavior, and social skills), anxiety, depression, and repeated falls.

R11's Service Plan dated May 1, 2023, included medication administration, bathing, assistance with CPAP (continuous positive airway pressure machine to assist with sleep apnea) and TED (thrombo-embolic deterrent) stockings (used to minimize risk of blood clots in the legs), and 24-hour supervision and visual checks in the memory care unit.

On May 2, 2023, at 8:00 a.m. unlicensed personnel (ULP)-DD was observed to administer oral medications to R11, apply a topical antifungal cream to her skin and provided stand by assistance for ambulation to the dining room.

R11's Fall incident report dated April 17, 2023,

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{01620}	Continued From page 13	{01620}		

indicated information regarding a witnessed fall. It read, "Daughter was walking with the resident down the hall and brought over a trash can for her to spit some food out of her mouth. When the resident tried to spit, she lost her balance and fell to the floor hitting her head and causing a head laceration. The registered nurse (RN) was notified immediately by the staff. Vital signs-99% (oxygen saturations-indicate the percentage of oxygen in a person's blood), 109/79 (blood pressure), 67 (pulse). Pressure was placed on the head wound to stop the bleeding. Hospice on call was notified and gave permission to transport the resident to the emergency room for stitches. Daughter was present at time of the fall. EMS (emergency medical services) assisted the resident off the floor and onto the stretcher to transport her when they arrived. Injuries observed at the time of incident: Laceration, Injury location: back of head. Level of pain using PAINAD scale (a number score scale used to determine the level of pain for non-verbal patients/patients with advanced dementia): 9, noting occasional labored breathing, short period of hyperventilation (one point), Negative vocalization (two points), Facial expression: grimacing (two points), Body language: rigid, fists clenched, knees pulled up, pushing or pulling away, or striking out (two points), Consolability: unable to console, distract or reassure (two points)." The Fall incident report indicated R11 was sent to the ER and received four staples.

On May 2, 2023, the surveyor requested the most recent comprehensive assessment completed for R11. MN JSL Comprehensive-V2 assessment, with type noted to be: Change of Condition, dated March 31, 2023, was provided.

R11's Progress Notes as written by registered

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{01620}	Continued From page 14 nurse (RN)-Z indicated: -dated April 17, 2023, Daughter was walking with the resident down the hall and brought over a trash can for her to spit some food out of her mouth. When the resident tried to spit, she lost her balance and fell to the floor hitting her head and causing a head laceration. RN was notified immediately by staff. VS 99% 97.6, 109/79, 67. Pressure was placed on the wound to stop the bleeding. Hospice on call (nurse) was notified and gave permission to transport the resident to the emergency room for stitches. Daughter was present at time of fall. EMS assisted the resident off the floor and onto the stretcher to transport her when they arrived. -dated April 18, 2023, RN followed up with the resident after the fall she had yesterday. She's had increased behaviors and pain today. This morning she was more resistant to cares and did not want anyone talking to her or touching her. Due to her increased behaviors the RN was unable to get follow up vitals on the resident. Additional documentation read Resident had some increased agitation today. She kept telling staff and hospice to leave her alone and don't touch her. Staff found her in another resident's room and using redirection was unsuccessful. She refused to take her scheduled Haldol and Hydromorphone while hospice was visiting. Hospice ordered scheduled Fentanyl patches for more continuous pain control as well as Haldol SC (subcutaneous injection) PRN (as needed) for agitation. The licensee failed to complete an assessment following the previous day's emergency room visit, where R11 received 4 staples for a laceration on the back of her head and with a noted increase in agitation the following day. The licensee failed to indicate the presence of, assess or document the condition of the head	{01620}		

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{01620}	Continued From page 15	{01620}		

laceration/staples, and failed to recognize the possibility of a change in condition with R11's noted increased agitation. Additionally, the licensee failed to document any further assessment or condition of R11's staples/scalp laceration until the staples were removed on May 2, 2023.

On May 2, 2023, at 2:15 p.m. RN-Z confirmed she had not completed an assessment for a change in condition following R11's fall and return from the ER with newly placed staples. Regional nurse specialist (RNS)-E stated the incident/ER visit did not follow their COC (change of condition) indicator. Additionally, RN-Z and RNS-E stated, "There were a bunch of people assessing R11 which included the hospice team, who made several medication changes and stated R11 may be changing." RNS-E stated the licensee filed a MAARC (Minnesota Adult Abuse Reporting Center) report due to the fall with a head laceration and R11 not having received any imaging of her head after the fall.

The licensee's undated, Change of Condition indicator document referenced a list of Change of Condition indicators to include 5. Change in behaviors such as new onset or worsening wandering/exit seeking, aggressive behaviors, new or worsening refusal of cares, new onset or worsening depressive symptoms.

The licensee's Assessments, Reviews and Monitoring policy dated August 1, 2021, indicated "Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident."

No further information was provided.

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{02180}	Continued From page 16	{02180}		
{02180} SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Existing housing with services establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted living facility license must provide residents with regular access to outdoor space. A licensee with new construction on or after August 1, 2021, or a new licensee that was not previously registered under chapter 144D prior to August 1, 2021, must provide regular access to secured outdoor space on the premises of the facility. A resident's access to outdoor space must be in accordance with the resident's documented care plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure behavioral symptoms were identified and were addressed on the care plan for one of four residents (R11). 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	{02180}		

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{02180}	Continued From page 17 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee held an assisted living with dementia care license, effective February 1, 2023. R11's diagnoses included Alzheimer's disease, (changes in the brain affecting memory, thinking, behavior, and social skills), anxiety, depression, and repeated falls. R11's Service Plan dated May 1, 2023, included medication administration, bathing, assistance with CPAP (continuous positive airway pressure machine to assist with sleep apnea) and TED (thrombo-embolic deterrent) stockings (used to minimize risk of blood clots in the legs), and 24-hour supervision and visual checks in the memory care unit. On May 2, 2023, at 8:00 a.m. ULP-DD was observed to administer oral medications to R11, apply a topical antifungal cream to her skin, and provided stand by assistance for ambulation to the dining room. R11's Medication Administration Record (MAR) dated April 2023, indicated she received medications to include Sertraline 100 milligrams (mg), one tablet orally, daily for anxiety, haloperidol (Haldol) 0.5 mg one tablet three times daily for agitation/delirium, haloperidol 0.5 mg every four hours as needed for agitation/delirium, and Haldol 5 mg/ml (milliliters) IM (intramuscular) injection every 30 minutes as needed for agitation.	{02180}		

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{02180}	Continued From page 18 R11's service plan/care plan lacked specific behaviors/symptoms and non-pharmalogical interventions to implement for behavioral symptoms that negatively impact the resident and others. On May 3, 2023, at 11:30 a.m. registered nurse (RN)-Z stated the licensee has been working through all residents in memory care to include this information, and had not gotten to R11 yet. The licensee's ALDC (assisted living dementia care) behavioral symptoms, interventions and nonpharmacological approaches policy dated August 1, 2021, indicated the licensee would identify behavioral symptoms that negatively impact other residents and others in the assisted living facility and evaluate to determine potential interventions to minimize such behaviors. Interventions would be identified on the care plan or service plan. No further information was provided.	{02180}		

Electronically Delivered

March 3, 2023

Licensee
AbiliT Holdings (Prairie Meadows)
800 5th Avenue Northwest
Kasson, MN 55944

RE: Project Number(s) SL24053015

Dear Licensee:

On February 2, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on November 4, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the November 4, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on November 4, 2022, found not corrected at the time of the February 2, 2023, follow-up evaluation and/or subject to penalty assessment are as follows:

0250-Conditions-144g.20 Subdivision 1- $500.00
0510-Infection Control Program-144g.41 Subd. 3- $500.00
0550-Resident Grievances; Reporting Maltreatment-144g.41 Subd. 7- $500.00
0620-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (a)
0630-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (b)
0640-Posting Information For Reporting Suspected C-144g.42 Subd. 7
0650-Employee Records-144g.42 Subd. 8
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9- $500.00
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10- $500.00
0730-Contents Of Resident Record-144g.43 Subd. 3
0900-Contract Required-144g.50 Subdivision 1
0920-Contract Information-144g.50 Subd. 2 (c)
0940-Contract Information-144g.50 Subd. 2 (e; 5-7)
0950-Designation Of Representative-144.50 Subd. 3
0970-Waivers Of Liability Prohibited-144.50 Subd. 5
1350-Temporary Staff-144g.60 Subd. 5
1370-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (a)
1380-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (b)
1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4
1460-Orientation Of Staff And Supervisors-144g.63 Subdivision 1
1540-Training In Dementia Care Required-144g.64 (a)

1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E)
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f)
1710-Individualized Medication Monitoring And Reas-144g.71 Subd. 3
1730-Individualized Medication Management Plan-144g.71 Subd. 5
1750-Delegation Of Medication Administration-144g.71 Subd. 7
1880-Storage Of Medications-144g.71 Subd. 19- $500.00
1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3
1950-Administration Of Treatments And Therapy-144g.72 Subd. 4
1960-Documentation Of Administration Of Treatments-144g.72 Subd. 5
1970-Treatment And Therapy Orders-144g.72 Subd. 6
2170-Services For Residents With Dementia-144g.84
2180-Services For Residents With Dementia-144g.84
3000-Timing Of Report-626.557 Subd. 3

The details of the violations noted at the time of this follow-up evaluation completed on February 2, 2023 (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.

Also, at the time of this follow-up evaluation completed on February 2, 2023, we identified the following violation(s):

0330-Information Provided By Facility-144g.30 Subd. 4
1740-Administration Of Medication-144g.71 Subd. 6

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. 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 investigation, and as otherwise needed.

IMPOSITION OF FINES:
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.

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 000}	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 SL24053015 On January 30, 2023, through February 2, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 4, 2022. At the time of the survey, there were 42 residents: 33 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued.	{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.	
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	{0 250}		

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{0 250}	Continued From page 1 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, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (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; (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	{0 250}		

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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
{0 250}	Continued From page 2 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). The findings include: During prior survey exited on November 4, 2022, on October 31, 2022, at 9:58 a.m. during the	{0 250}		

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{0 250}	Continued From page 3	{0 250}		

entrance conference registered nurse (RN)-C stated the licensee's employees in charge of the facility 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.

- I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which

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{0 250}	Continued From page 4 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 existence of a management agreement or subcontract.	{0 250}		

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{0 250}	Continued From page 5 - 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 authorized agent on May 31, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of January 31, 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; -orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; -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; -reminders for medications, treatments, or	{0 250}		

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{0 250}	Continued From page 6 exercises, if provided; -conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; -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, 0630, 0660, 1350, 1370, 1380, 1440, 1460, 1540, 1620, 1710, 1730, 1740, 1750, 1880, 1940, 1950, 1960, 1970 and 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.	{0 250}		
0 330 SS=D	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by:	0 330		

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0 330	Continued From page 7 Based on observation, interview and record review, the licensee failed to provide accurate and truthful information for employee records for two of two unlicensed personnel (ULP-U, ULP-S). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee failed to provide accurate documentation for employee training and competency evaluation records. ULP-U During the entrance conference on January 30, 2023, at 11:47 a.m. community director (CD)-V stated the licensee was utilizing staff from a supplemental staffing agency to maintain staffing at the facility. On January 31, 2023, at 7:54 a.m. ULP-U was observed to assist R2 with dressing and grooming. On January 31, 2023, at 6:35 a.m. ULP-U stated she had not received any orientation or training and competency from any nurse of the licensee. ULP-U stated, "Just aides do orientation, no one else showed me anything, just aides". ULP-U stated, "other aides showed me around the facility". ULP-U stated she worked in the facility prior to today, "once in a while".	0 330		

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0 330	Continued From page 8 On January 31, 2023, at 8:11 a.m. the surveyor asked CD-V for ULP-U's employee file the licensee had on file. CD-V stated, "[licensed practical nurse (LPN)-W] would have that". ULP-U employee record contained New Agency Orientation Guideline, a job description and multiple nurse delegation documents for training and competency of delegated task signed by ULP-U and LPN-W, with a date of January 5, 2023. On January 31, 2023, at 9:23 a.m. the surveyor showed ULP-U documented information in ULP-U's record. ULP-U stated, "the nurse [LPN-W] had me sign today and write the date of January 5, 2023" for the date of signature. ULP-U stated, "the aide went over some of the information" in the record prior to today. ULP-U stated, "The nurse went over it with me today". On January 31, 2023, at 9:25 a.m. LPN-W stated she had ULP-U back date information in ULP-U's record today for the date of January 5, 2023. LPN-W stated some of the training was completed prior to today for ULP-U by her and some of it was completed today. LPN-W stated five documents were completed today for training and she had ULP-U back date the documents with the date of January 5, 2023. ULP-S ULP-S's date of hire was August 22, 2017. ULP-S provided direct care and services to the licensee residents. On January 30, 2023, at 11:00 a.m. ULP-S was observed to administer medications to R11 and R12.	0 330		

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0 330	Continued From page 9 ULP-S's record included multiple documented training and competency for delegated treatment tasks, some delegated medication tasks and activities of daily living tasks with name signature of a RN with no date of signature or the signature date of December 7, 2022, signature of name for LPN-W with no date and signature of name for ULP-S with date of January 20, 2023. On January 31, 2023, at 12:22 p.m. LPN-W stated "I think she [the RN] makes copies and doesn't change the date, but I can't say for sure. I wasn't here for training." On February 1, 2023, at 12:28 p.m. community director (CD)-V stated regarding LPN-W having ULP-U back date documents, "we don't do that, not our practice". CD-V stated, "when training done, document on the day done". RN-D verified training and competency for delegated tasks was to be completed by an RN. On February 2, 2023, at 9:05 a.m. CD-V stated the licensee had completed an investigation regarding backdating ULP-U's records to January 5, 2023, and the different dates for signature by the RN and ULP-S for training and competency tasks. The investigation information provided to the surveyor indicated LPN-W "reported that she falsified agency training documents"; LPN-W "stated she backdated training to 01/05/2023 on 01/30/2023 on 2-4 agency training documents because (she) wanted the dates to match." LPN-W "then stated that on the same day she also had an RA [resident assistant] sign a task delegation packet with an RN's signature on it that she had photocopied". No further information was provided.	0 330		

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0 330	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 330		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing	{0 510}		

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{0 510}	Continued From page 11	{0 510}		

standards for infection control for current recommendations for COVID-19. In addition, one of two unlicensed personnel (ULP-T) failed to wash hands appropriately during direct cares. 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:

FACIAL MASK EMPLOYEE
The licensee failed to ensure employee facial masks were worn appropriately.

On January 30, 2023, at 9:32 a.m. cook (C)-L was observed to be walking down the hallway carrying a tray of food to a resident's apartment. C-L's facial mask was worn below the nose with a mustache visible.

On January 30, 2023, at 11:42 a.m. C-L was observed to serve residents lunch in the main dining room. C-L's facial mask was worn below the nose with a mustache visible when in the dining room serving residents' food.

On January 30, 2023, at 10:58 a.m. ULP-S was observed to bring residents in the memory care unit to the dining room area. ULP-S's facial mask was worn below nose.

On February 2, 2023, at 8:56 a.m. community

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{0 510}	Continued From page 12 director (CD)-V stated, "We included that in mandatory meeting", referring to the proper way to wear a facial mask. CD-V stated, "We will redo it until it sticks". CD-V verified facial masks were to be worn by staff persons. HAND WASHING EMPLOYEE On January 30, 2023, at 9:25 a.m. ULP-T was observed to administer medications to R10. With the same gloves worn when giving R10's medications, ULP-T continued to gather equipment for R9's blood glucose check, completed the blood glucose check, disposed of the lancet (small needle used to prick the skin to get a blood sample) and the blood glucose test strip. ULP-T kept the same gloves on, returned equipment to the cupboard, closed the cupboard door, locked the door with a key, and then removed her gloves and washed her hands. On February 2, 2023, at 10:45 a.m. registered nurse (RN)-D stated she expected ULP-T to remove her gloves and wash her hands between each resident's cares, medication administration and immediately following performing a blood glucose check when contamination could occur with blood. The licensee's hand washing policy dated August 1, 2021, indicated hand washing would be performed by all employees, as necessary between tasks and procedures, and after bathroom use, to prevent cross-contaminations. No further information was provided.	{0 510}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	{0 550}		

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{0 550}	Continued From page 13 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the 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. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. 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. 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	{0 550}		

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{0 550}	Continued From page 14 include: -information about the facility's grievance procedure; On January 30, 2023, at 9:10 a.m. observation of the facility identified posted facility grievance information above the residents' mail boxes in the main area of the assisted living facility; however, the posted information did not include the the facility procedure for persons to file a grievance. On February 1, 2023, at 1:17 p.m. observation of the facility with community director (CD)-V identified the posted facility grievance information above the residents' mail boxes did not include the the facility procedure for persons to file a grievance. The licensee's Complaint/Grievance Posting policy dated August 2021, indicated the licensee would post, in a conspicuous place, the information about the licensee's complaint/grievance procedure. No further information was provided.	{0 550}		
{0 620} SS=E	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the	{0 620}		

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{0 620}	Continued From page 15 licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) a suspected maltreatment for one of one resident (R2) and significant medication errors for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) a suspected maltreatment for R2 and significant medication errors for R1 and R3 as noted below from a previous survey exited on November 4, 2022. R2 R2's service plan/care plan last reviewed April 15, 2022, included assistance with activities of daily living and administration of medications. R2's incident report dated August 7, 2022, indicated resident assistant (RA) witnessed a resident with a cup that contained bleach. "Resident states she drank some of it." The registered nurse (RN) on call was notified. RN asked if the resident had any signs of ingesting the bleach. The resident did not appear to have any odor of bleach on her. Poison control was called and stated that if the resident had ingested	{0 620}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

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bleach, she would have burns on her mouth. The resident did not have any signs of ingesting bleach. A family member was notified and did not wish to have R1 sent into the emergency room (ER). RN instructed staff to continue to monitor R1 for nausea and vomiting throughout the night. The report further indicated the laundry room door had been left open. "RN reiterated to staff the importance of keeping the laundry room door closed and lacked to keep chemicals away from resident's."

The licensee failed to ensure immediate report of the incident to MAARC.

On November 3, 2022, at 1:33 p.m. RN-C and regional nurse specialist (RNS)-E stated the licensee's process for incidents was to fill out an incident report, notify the doctor, notify family, talk to staff and provide education. RN-C stated she had not filed a report to MAARC regarding the incident. RN-C stated R2 "did not drink bleach," as the poison control center informed if R2 had drank some of the bleach, R2 would of had "burns and blisters inside mouth." When asked if the incident had been reported to MAARC, RNS-E stated, "I don't recall this one." When asked when a MAARC report would be reported, RNS-E stated, "If negative outcome, make a MAARC report."

R1
R1's service plan/care plan dated October 20, 2022, included medication administration, insulin administration and blood sugar checks.

R1's Medication Error report dated June 14, 2022, documented by licensed practical nurse (LPN)-R, indicated she received a call from the RA informing the resident's insulin was still on

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hold. Most of the other medications were taken off hold when the resident returned from the hospital. The resident's blood sugar was 345. The RN who received the resident back to the community was contacted. "She instructed to take Lantus 24 units off hold." A phone call was placed to the doctor on call to verify how many units of insulin was to be given. The doctor on call "after review of resident hospital stay and discharge papers informs that 10 units of Lantus was to be given." The doctor was informed R1 received 24 units of Lantus at 1945 (7:45 p.m.) The doctor gave a verbal order to recheck blood sugar at 2145 (9:45 p.m.) If above 120, no further action needed tonight. Recheck on blood sugar was 249.

R1's After Visit Summary dated June 1, 2022, through June 14, 2022, indicated Lantus 10 units under the skin at bedtime. Last time this was given: 10 units on June 13, 2022, 7:00 p.m.

The licensee failed to ensure immediate report of a significant medication error to MAARC.

On November 3, 2022, at 8:41 a.m. LPN-R stated, "Yes, [R1] returned from the hospital" on June 14, 2022. LPN-R stated R1's family member "sat orders on [RN-C's] desk " and RN-C stated "she would take care of them" and "asked me to fax two to three orders to the pharmacy. I got a call [from staff person] insulin was still on hold" (in the computer system) and I informed the staff person to call RN-C. RN-C "told the staff person to tell [LPN-R] to take the insulin off hold. I was not comfortable with that, so I texted [RN-C] and asked if the dose was right" and RN-C "said it was right, take off hold. So I did. My gut said I shouldn't have done that. I couldn't find anything in the system [regarding orders upon return from

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the hospital], so I called the on-call doctor to verify the dose to be given and informed [R1] had received 24 units instead of 10 units."

On November 3, 2022, at 1:33 p.m. RN-C stated, "After coming back from the hospital [R1's] insulin was reduced due to after surgery [R1] was not eating as much. Orders were sent back with her and I asked [LPN-R] to enter [into the licensee's computer system] and fax the pharmacy. Re-entering the medication orders [into the licensee's computer system] did not happen. RNS-E stated, "Guidance if negative outcome would report. No negative outcome with glucose monitoring." RNS-E stated, "No" to the incident being reported to MAARC.

R3
R3's service plan/care plan dated August 16, 2022, included administration of medications and INR (international normalized ratio/lab calculation based on prothrombin test results; a test measuring how long it takes a blood clot to form in a blood sample) by an outside agency.

R3's Medication Error report dated June 10, 2022, indicated resident's last dose of warfarin was on Thursday, June 9, 2022. R3 was unaware that he did not receive his warfarin. The med passer informed nursing that warfarin was not on E-MAR(electronic medication administration record) to be given.

R3's Medication Administration Record (MAR) dated June 2022, identified no signatures by the staff for administration of warfarin for the dates of June 9, 10, 11, and 12, 2022.

R3's clinic notes indicated the following:
-dated June 8, 2022, indicated results for INR

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was "2.5" and anticoagulation dosing "Goal:2-3". New warfarin dosing: warfarin 1.5 milligrams (mg) Sunday; and warfarin 2.5 mg Monday, Tuesday, Wednesday, Thursday, Friday and Saturday. Recheck INR one week June 15, 2022.
-dated June 13, 2022, discontinue previous warfarin orders due to missed dosing; start warfarin 5 mg daily Monday and Tuesday. Recheck INR on Wednesday June 15, 2022.
-dated June 15, 2022 INR value today "1.6. Goal: 2-3". Warfarin 2.5 mg Wednesday, Thursday, Friday, Saturday, Sunday, Tuesday and 1.5 mg on Monday. Recheck INR one week June 22, 2022.

R3's INR value fell below the goal of "2-3" on June 15, 2022, due to missed doses of warfarin. The licensee failed to ensure immediate report of a significant medication error to MAARC.

On November 3, 2022, at 8:41 a.m. LPN-R stated even though R3's MAR showed R3 did not receive medication on the dates of June 9, 10, 11 and 12, 2022, R3 had received warfarin on June 9, 2022. LPN-R stated, "I saw from the pack dose June 9 dose was given, but the staff person was unable to sign for giving the medication because the medication was not on the EMAR." LPN-R stated R3's INR on June 8 was "2.5 and on June 15 was "1.6". LPN-R stated, "Yes, [R1's INR] dropped". LPN-R stated regarding if the medication error had been reported to MAARC, "I'm going to say no, didn't even think about it."

On November 3, 2022, at 1:33 p.m. RNS-E stated regarding if the medication error had been reported to MAARC, "I'm usually involved in any VA [vulnerable adult/report] done. I don't recall one."

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{0 620}	Continued From page 20 On January 30, 2023, at 11:47 a.m. RNS-E stated via phone during the entrance conference, "I never went back and reported anything. We did reeducation and training with staff" (since survey exited November 4, 2022). RNS-E stated, "No negative outcome [to residents] that's why not reported. I never went back and reported due to so many months prior". RNS-E stated, "Yes, anyone can report and if any questions or concerns they can bring to me". On January 30, 2023, at 1:05 p.m. community director (CD)-V was informed by the surveyor the licensee needed to report the above incidents to MAARC for R2, R1 and R3. On February 1, 2023, at 12:11 p.m. RN-D provided the MAARC reports for R2, R1 and R3 the licensee had filed through MAARC. The reports identified R2's MAARC report was filed on January 31, 2023, at 3:22 p.m.; R1's MAARC report was filed on January 31, 2023, at 4:16 p.m. and R3's MAARC report was filed on January 31, 2023, at 5:08 p.m. The licensee's Vulnerable Adult Maltreatment Prevention and Reporting policy dated August 1, 2021, indicated maltreatment was defined as neglect, abuse, and exploitation/theft. Staff who suspect maltreatment of a resident (abuse, financial exploitation, or neglect), or who has knowledge that a resident has sustained a physical injury which is not reasonably explained would "f. If the assisted living director or nurse confirms the suspicion of maltreatment, they will contact the Minnesota Adult Abuse Reporting Center (MAARC). Such report must be made no later than 24 hours after the maltreatment was first suspected."	{0 620}		

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{0 620}	Continued From page 21 No further information was provided.	{0 620}		
{0 630} SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement an individual abuse prevention plan that included an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults for six of six residents (R1, R2, R8, R3, R4, R9). 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).	{0 630}		

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{0 630}	Continued From page 22 The findings include: R1 On January 31, 2023, at 8:34 a.m. unlicensed personnel (ULP)-J was observed to administer medications to R1, check R1's blood pressure, check R1's blood sugar and applied knee high TED (thrombo embolic deterrent) stockings (used to reduce swelling) to R1's lower legs/feet. R1's Individual Abuse Prevention Assessment and Plan dated November 2, 2022, read for "is client vulnerable due to: ability to report abuse or neglect," with a response of "no"; however, the assessment indicated for "is client vulnerable due to: ability to give accurate information consistently" with response of "yes." In addition, the assessment failed to address R1's susceptibility to abuse by another individual, including other vulnerable adults. R2 On January 31, 2023, at 7:54 a.m. ULP-U was observed to assist R2 with dressing and grooming. R2's Individual Abuse Prevention Assessment and Plan dated January 8, 2023, indicated for "is client vulnerable due to: ability to report abuse or neglect" with a response of "yes." The assessment failed to address R2's susceptibility to abuse by another individual, including other vulnerable adults. R8 On January 31, 2023, at 7:52 a.m. R8 was observed eating breakfast in the dining room of the memory care unit. R8 was eating	{0 630}		

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{0 630}	Continued From page 23 blueberry/strawberry mix, sausage patty and scrambled eggs. R8's Individual Abuse Prevention Assessment and Plan dated June 16, 2022, indicated for "is client vulnerable due to: ability to report abuse or neglect" with a response of "yes." The assessment failed to address R8's susceptibility to abuse by another individual, including other vulnerable adults. On January 30, 2023, at 11:47 a.m. regional nurse specialist (RNS)-E stated the residents abuse prevention plans were "all individualized". RN-D stated the licensee was "working on doing that [adding information for susceptibility to abuse by another individual, including other vulnerable adults]. The request is in to PCC" (point click care/computer software program). On February 2, 2023, at 9:05 a.m. community director (CD)-V verified R1, R2 and R8's Individual Abuse Prevention Assessment and Plans failed to address susceptibility to abuse by another individual, including other vulnerable adults. R3 On January 31, 2023, at 7:00 a.m. ULP-Q was observed to provide oral medications, topical cream to feet, compression wraps to both lower extremities, suprapubic catheter site care, urinary bag maintenance and exchange, light sponge bath and dressing assistance. R3's Individualized Abuse Prevention Assessment and Plan (IAPP) dated January 12, 2023, addressed his risk to abuse self or others, but but failed to address the susceptibility to abuse by another individual, including other vulnerable	{0 630}		

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{0 630}	Continued From page 24 adults. R4 On January 31, 2023, at 2:00 p.m. ULP-Q stated R4 was currently resting in bed, staff continue to provide all personal cares, and stated R4 no longer wore her TED stockings. R4's IAPP dated September 22, 2022, addressed her risk to abuse self or others, but failed to address the susceptibility to abuse by another individual, including other vulnerable adults. R9 On January 30, 2023, at 9:20 a.m. ULP-T was observed to provide a blood glucose check to R9 while in her apartment. R9's IAPP dated January 17, 2023, addressed her risk to abuse self or others, but failed to address her susceptibility to abuse by another individual, including other vulnerable adults. On February 2, 2023, at 10:45 a.m. registered nurse (RN)-D confirmed the residents above lacked the required content of the IAPP. The licensee's Individual Abuse Prevention Plan policy (6.03) dated August 1, 2021, indicated the plan would contain an individualized review or assessment of the person's susceptibility to abuse by another individual including: other vulnerable adults. No further information was provided.	{0 630}		
{0 640} SS=C	144G.42 Subd. 7 Posting information for reporting suspected c	{0 640}		

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{0 640}	Continued From page 25 The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (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 post the 911 emergency number in common areas of the assisted living facility. This had the potential to affect all 42 residents receiving assisted living services, staff, and visitors. 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 January 30, 2023, at 9:10 a.m. in the conference room of the facility a large 911 sign was posted above the phone located on the wall inside the entrance door to the conference room.	{0 640}		

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{0 640}	Continued From page 26 On February 1, 2023, at 1:17 p.m. observation of the facility with community director (CD)-V identified the only 911 sign posted was above the phone located on the wall inside the entrance door to the conference room. There were no posted 911 emergency number in common areas of the assisted living facility, including the memory care unit. No further information was provided.	{0 640}		
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced	{0 650}		

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{0 650}	Continued From page 27 by: Based on observation, interview, and record review, the licensee failed to ensure employee records included a current job description for one of eight unlicensed personnel (ULP-U) and failed to ensure documentation of training and competency of medication administration by a registered nurse (RN) for one of three unlicensed personnel (ULP-S). 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-U ULP-U record lacked evidence of job description. During the entrance conference on January 30, 2023, at 11:47 a.m. community director (CD)-V stated the licensee was utilizing staff from a supplemental staffing agency to maintain staffing at the facility. On January 31, 2023, at 7:54 a.m. ULP-U was observed to assist R2 with dressing and grooming. ULP-U's record lacked a current job description, including qualifications, responsibilities and identification of staff persons providing supervision.	{0 650}		

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{0 650}	Continued From page 28 On January 31, 2023, at 6:35 a.m. ULP-U stated she had not received any orientation or training and competency from any nurse of the licensee. ULP-U stated, "Just aides do orientation, no one else showed me anything, just aides". ULP-U stated, "other aides showed me around the facility". ULP-U stated she worked in the facility prior to today, "once in a while". On January 31, 2023, at 8:11 a.m. the surveyor asked CD-V for ULP-U's employee file the licensee had on file. CD-V stated, "[licensed practical nurse (LPN)-W] would have that". ULP-U employee record contained a job description signed by ULP-U and LPN-W, with date of signatures January 5, 2023. On January 31, 2023, at 9:23 a.m. the surveyor showed ULP-U documented information in ULP-U's record. ULP-U stated, "the nurse [LPN-W] had me sign today [the job description] and write the date of January 5, 2023" for the date of signature. ULP-U stated,"the aide went over some of the information" in the record prior to today. ULP-U stated, "The nurse went over it with me today". On January 31, 2023, at 9:25 a.m. LPN-W stated ULP-U was provided a copy of job description prior to today. LPN-W stated she had ULP-U backdate a job description for January 5, 2023 and placed the information in ULP-U's record today. ULP-S ULP-S record lacked documented evidence of training and competency evaluation for all routes of medication administration and training and competency evaluation for preparing medications	{0 650}		

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{0 650}	Continued From page 29	{0 650}		

for resident unplanned times away.

ULP-S's date of hire was August 22, 2017. ULP-S provided direct care and services to the licensee residents.

On January 30, 2023, at 11:00 a.m. ULP-S was observed to administer medication to R11 and R12.

ULP-S's record included multiple medication competencies sheets for various routes signed by employee ULP-S on October 28, 2021. There was no signature of an RN on any of the sheets.

On February 1, 2023, at 8:40 a.m. ULP-S stated she started working for the licensee since 2017. ULP-S stated she was "trained here [in the facility] for all medication almost right away after hired. I came from another facility I was passing medications at". ULP-S stated, "Didn't have a big process back then" for medication administration training. ULP-U stated she was trained and competency evaluated by an RN for medication administration, but the RN no longer works for the licensee. ULP-S provided a name of the former RN had trained her for medication administration.

On February 1, 2023, at 10:33 a.m. ULP-S stated the multiple medication competencies sheets for various routes signed by her dated October 28, 2021, was from an employee training class with multiple employees where the RN read through the competency sheets for review of medication administration procedures and had us sign the sheets for understanding of the procedures.

On February 1, 2023, at 9:36 a.m. administrative assistant (AA)-X stated, "I can't find it. I know I seen it, but that's next to nothing", referring to

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{0 650}	Continued From page 30 ULP-S's training and competency evaluations for medication administration. On February 1, 2023, at 12:28 p.m. CD-V stated regarding LPN-W having ULP-U back date documents, "we don't do that, not our practice". CD-V stated, "when training done, document on the day done". The licensee's Orientation of Staff and Supervisor's and Content policy dated August 1, 2021, indicated additional orientation would include the staff persons job description upon hire. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated a copy of all education, training, competency testing shall be kept in each employee's personnel file. No further information was provided.	{0 650}		
{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.	{0 660}		

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{0 660}	Continued From page 31 (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to 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 previous survey exited on November 4, 2022, identified the licensee's TB facility risk assessment dated September 15, 2022, indicated the licensee was a low risk. ULP-U During the entrance conference on January 30, 2023, at 11:47 a.m. community director (CM)-V stated the licensee was utilizing staff from a supplemental staffing agency to maintain staffing at the facility. On January 31, 2023, at 7:54 a.m. ULP-U was observed to assist R2 with dressing and	{0 660}		

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{0 660}	Continued From page 32 grooming. Unlicensed personnel (ULP)-U's record lacked documented evidence of TB screen and documented education for TB pathogenesis and transmission, signs and symptoms of active TB disease, and the license's health care setting's infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections employees were responsible for implementing. On January 31, 2023, at 6:35 a.m. ULP-U stated she had not received any orientation or training and competency from any nurse of the licensee. ULP-U stated, "Just aides do orientation, no one else showed me anything, just aides". ULP-U stated, "other aides showed me around the facility". ULP-U stated she worked in the facility prior to today, "once in a while". On February 1, 2023, at 12:28 p.m. community director (CD)-V verified ULP-U's record lacked documented evidence of TB symptom screen and documented education for TB. ULP-T ULP-T had a hire date of October 4, 2022. On January 30, 2023, at 9:20 a.m. ULP-T was observed to provide a blood glucose check to R9 while in her apartment. ULP-T's record included the first of two, TST (tuberculin skin test) dated August 19, 2022, but lacked the required second TST. Additionally her record lacked evidence of a completed TB symptom screening. On February, 1, 2023, at 1:00 p.m. CD-V stated she would search more for this.	{0 660}		

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{0 660}	Continued From page 33 On February, 2, 2023, at 9:00 a.m. CD-V stated ULP-T's record lacked evidence of TB symptom screen and a second TST. The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated all health care settings in Minnesota should have an up-to-date TB infection control program that included: Written TB infection control procedures; Health care worker (HCW) education. TB training is required at time of hire for all health care workers and the content should focus on basic information: TB pathogenesis and transmission, Signs and symptoms of active TB disease, and 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. An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. The licensee's Tuberculosis Screening policy dated September 25, 2022, indicated indicated staff would be educated regarding TB at the time of hire and annually. The content of the training would focus on basic information about: TB pathogenesis and transmission, Signs and symptoms of active TB disease, and the community infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing and other communicable infections. New staff would be screened for active signs of TB using the	{0 660}		

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{0 660}	Continued From page 34 baseline TB screening tool for HCW's. New staff would have an IGRA blood test or a two-step Mantoux conducted with results documented. No further information was provided.	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written	{0 680}		

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{0 680}	Continued From page 35	{0 680}		

emergency disaster plan with the required elements was posted; failed to ensure emergency exit diagrams were posted; and 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 42 residents, 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:

The licensee lacked the following:;
-posting of an emergency disaster plan prominently;
-post emergency exit diagrams on each floor; and
-Appendix Z (emergency preparedness) requirements

EMERGENCY DISASTER PLAN POSTED
On January 30, 2023, at 9:10 a.m. observation of the facility identified no posted facility emergency disaster plan.

On January 30, 2023, at 11:47 a.m. community director (CD)-V stated, "No not yet", regarding the facility emergency disaster plan posted prominently.

EMERGENCY EXIT DIAGRAMS
On January 30, 2023, at 9:10 a.m. observation of the facility identified no posted facility emergency

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{0 680}	Continued From page 36 exit diagrams posted in the locked memory care unit. On February 1, 2023, at 1:17 p.m. observation of the facility with CD-V no posted facility emergency exit diagrams posted in the locked memory care unit. EMERGENCY EXIT DIAGRAMS On January 30, 2023, at 9:10 a.m. observation of the facility identified the second floor diagrams lacked clearly marked exits at both elevators and along both hallways of the second floor. On February 1, 2023, at 1:10 p.m. CD-V confirmed each of the posted diagrams located on the second floor lacked exits on each diagram. CD-V stated all of the diagrams had been updated and was uncertain as to why these were missed. CD-V stated the diagrams would be corrected at once. EP PROGRAM (APPENDIX Z) On February 1, 2023, at 10:00 a.m. the surveyor and CD-V reviewed the contents of the licensee's EP Program. The licensee lacked the following required information according to Emergency Preparedness: Appendix Z: - risk assessment which considered hazards like care related emergencies, cyber-attacks, normal supply of essential resources and medical supplies, should consider duration of interruptions, consider emerging infectious diseases (EIDs); - document risk assessment for an all hazards approach, including EIDs as applicable, categorize the various probable risks by likelihood of occurrence, develop strategies for addressing	{0 680}		

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{0 680}	Continued From page 37 facility and community based risks (evacuation plans, staffing surges/shortages, back-up plans); - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - 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; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - develop a written communication plan; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan which includes contact information for Federal, State, tribal, regional and local EP staff; State Licensing and Certification Agency; and other sources of assistance; - communication plan which includes alternate means of communication with facility staff and Federal, State, tribal, regional and local emergency management agencies; - communication plan which includes method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general	{0 680}		

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{0 680}	Continued From page 38	{0 680}		

condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4);
- communication plan which includes means to providing information about the facility occupancy, needs, and it's 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;
- conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt form engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise

On February 1, 2023, at 11:00 a.m. CD-V stated she was relatively new to her position, and knew the (EP) binder did have some work completed after the previous survey in November 2022, and understood some of what was required with Appendix Z, but recognized the missing required content.

The licensee's Emergency Preparedness Plan Appendix Z Compliance policy dated August 1, 2021, indicated the licensee's emergency preparedness plan would include all required elements of appendix Z. The plan would be in writing and reviewed annually. The plan was based on our assisted living-based and

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{0 680}	Continued From page 39 community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan include four primary components: 1. Risk assessment and planning; 2. Policies and procedures; 3. A communication plan; 4. Staff training and exercises/drills. No additional information was provided.	{0 680}		
{0 730} SS=E	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	{0 730}		

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{0 730}	Continued From page 40 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 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 observation, interview, and record review, the licensee failed to ensure documentation of content in the resident's record as required for seven of seven residents (R1, R2, R7, R8, R3, R4, R9). 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:	{0 730}		

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{0 730}	Continued From page 41 R1 R1's service plan/care plan dated November 4, 2022, indicated R1 received services including assistance with activities, bathing, TED (thrombus embolic deterrent) hose/compression stockings (used to reduce swelling) applied as ordered, safety, fall interventions and home management (daily room tidy, housekeeping, trash removal). On January 31, 2023, at 8:34 a.m. unlicensed personnel (ULP)-J was observed to administer medications to R1, check R1's blood pressure, check R1's blood sugar and applied knee high TED stockings to R1's lower legs/feet. R1's documentation of services sheets dated January 2023, lacked consistent documentation of tasks provided for the following: -trash removal -visual checks every shift -orientation -ensure wearing proper footwear -bathing/shower assist -compression stockings R2 R2's service plan/care plan dated December 9, 2021, indicated R2 received services including activities, meals, assistance with transportation/appointments, pain, cardiac, bathing, grooming/oral hygiene, dressing/undressing, medication administration, weight monitoring, vitals, toileting, assistance with ambulation long distances, fall interventions, assistance with safety in emergency situations and skin condition. On January 31, 2023, at 7:54 a.m. ULP-U was observed to assist R2 with dressing and grooming.	{0 730}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

(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
{0 730}	Continued From page 42 R2's documentation of services sheets dated January 2023, lacked consistent documentation of tasks provided for the following: -linen changes every week -orientation -dressing -housekeeping/laundry -encourage extra fluids -hygiene/grooming -COVID-19 screening -trash removal daily -call pendant check monthly on day shift -visual checks eight times per eight hour shift -toileting one time during the night -behaviors and were you able to redirect R7 R7's record lacked the required content of a discharge summary. R7 was discharged from the facility on January 20, 2023, to another assisted living facility. R7's Progress Notes included "Discharge Summary" dated January 20, 2023. The summary included content of: resident name/move out date, reason for move out, disposition of belongings, disposition of medications (each medication name, dose, and # (number) of pills), pharmacy notified, "ADL [activities of daily living] Abilities: baseline", If waiver/required-notification to State, physician notified/date/time. R7's record lacked a discharge summary to include the required content as follows: -a summary of the resident's stay that included diagnoses, courses of illnesses, allergies, treatments and therapies, pertinent lab, radiology,	{0 730}		

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{0 730}	Continued From page 43	{0 730}		

and consultation results
-a final summary of the resident's status from the latest assessment or review under statute 144G.70, if applicable, that included the resident status, including baseline and current mental, behavioral, and functional status

On January 30, 2023, at 11:47 a.m. regional nurse specialist (RN)-E stated the licensee "always had" a discharge summary. RN-E stated, "We went over with nurses and using paper template, which includes plan too". RN-E stated information required for discharge summary was "all in template".

On February 1, 2023, at 1:15 p.m. RN-D stated, "I'll ask [RN-E] if more information. I did not see one. I'll look and see", referring to there being another discharge summary for R7 with the required content; however, no further information was provided.

R8
R8's service plan/care plan dated August 31, 2020, indicated R8 received services including activities, pain, risk of choking monitoring, bathing, dressing/undressing, meals, medication administration, treatments: CPAP/TED stockings/weights/vitals, toileting assist, lotion feet after shower, wheelchair assistance long distances, Mobility assistance, visual checks for safety, assistance with emergency situations, fall interventions, daily bed making/room tidy, housekeeping, laundry, trash removal and linen changes.

On January 31, 2023, at 6:35 a.m. ULP-U stated R8 was already awake and dressed. ULP-U stated she set up R8's toothbrush and he brushed his teeth, assisted R8 to shave, wash

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{0 730}	Continued From page 44 face, change incontinent product, dress and put on R8's TED stockings. R8's documentation of services sheets dated January 2023, lacked consistent documentation of tasks provided for the following: -call pendant check monthly on day shift -orientation every shift -bathing/shower assist -trash removal daily -hygiene/grooming -toileting -clean toilet bowl/mop bathroom floor -food/diet/nutrition -transfers to wheelchair -COVID-19 screening -dressing/undressing -laundry/linen change -visual checks eight times per shift On February 2, 2023, at 9:05 a.m. community director (CD)-V reviewed R1, R2 and R8's documentation of services sheets. CD-V verified R1, R2 and R8's sheets lacked consistent documentation by staff for providing the above services. CD-V stated the licensee was "working on with employees". R3 R3's record lacked documentation of tasks completed. R3's service plan/care plan indicated last service plan review completed January 13, 2023, indicated R3 received services that included bathing assistance, daily lower extremity compression wrap assistance, suprapubic catheter site care and catheter bag management, skin checks, medication administration, dressing cues with some hands-on assistance, visual	{0 730}		

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{0 730}	Continued From page 45	{0 730}		

checks every shift, housekeeping, and laundry. Resident receives wound care and INR (international normalized ratio/lab calculation based on prothrombin test results; a test measuring how long it takes a blood clot to form in a blood sample) by an outside agency.

On January 31, 2023, at 7:00 a.m. ULP-Q was observed to provide oral medications, topical cream to feet, compression wraps to both lower extremities, suprapubic catheter site care, urinary bag maintenance and exchange, light sponge bath, and dressing assistance. Two dressings were observed on R3's right foot. ULP-Q stated the wound care was completed by a "home health agency. The ULP do not do anything with the dressings."

Task sheet documentation
R3's Task Sheets dated January 2023, lacked consistent documentation of tasks completed to include:
-output (emptying catheter)
-Covid-19 screening

On February 2, 2023, at 9:25 a.m. RN-D verified the missing documentation on R3's Task sheets. She also clarified the task of "hydrocolloid dressings" which was understood to be for the ULP only to ensure the dressings are in place and intact and to notify the licensee's nurses if they were not in place. The licensee's nurses would then contact the home health agency to come and manage the wound dressing concern. The licensee did not manage any wound care for R3.

R4
R4's service plan/care plan dated November 1, 2022, indicated R4 received services to include medication management, weekly

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{0 730}	Continued From page 46	{0 730}		

bathing/showering/sponge bath assistance, grooming/oral hygiene, assistance with glasses and hearing aids, dressing assistance/cues, assistance each morning and evening with TED stockings, ace wrap to lower right extremity as needed, eating encouragement, cues to use walker, safety checks (eight times per shift), toileting assistance, escort to and from dining area and activities, housekeeping, laundry and housekeeping. Additionally, R4 began receiving hospice services on August 30, 2022.

On January 31, 2023, at 2:00 p.m. ULP-Q stated R4 was currently resting in bed, staff continued to provide all personal cares, and stated R4 no longer wore her TED (thromboembolic deterrent) stockings.

R4's Task Sheets dated January 2023, lacked consistent documentation of tasks completed to include:
-percentage of meal eaten
-toileting every two (2) hours
-Dressing/undressing each shift
-Orientation to the service plan/tasks performed on each shift
-Hygiene/Grooming
-COVID-19 screening
-Housekeeping
-Oral care assistance
-Escort to meals
-Wash eye glasses
-Visual checks 8 (eight) times each shift
-Food, Diet, and Nutrition

On February 2, 2023, at 9:30 a.m. RN-D verified the missing task documentation.

R9
R9's unsigned Service Plan dated January 17,

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{0 730}	Continued From page 47 2023, indicated she received services to include medication administration, blood glucose checks, assistance with transfers, showers, dressing, and toileting, and visual safety checks. On January 30, 2023, at 9:20 a.m. ULP-T was observed to provide a blood glucose check to R9 while in her apartment. R9's Task Sheets dated January 2023, lacked consistent documentation of tasks completed to include: -Visual checks every 1 (one) hour -Shower assist (Saturday/Tuesday) -Trash removal -Monthly vitals -Escorts to meals/activities -Dressing/undressing assistance On February 2, 2023, at 10:45 a.m. RN-D verified the missing documentation and clarified R9's visual checks were changed to every hour on January 17, 2023, and previously were four times per shift. The licensee's Resident Record-Documentation (2.25) dated August 1, 2021, indicated staff authorized to document in a resident record would do so for all medications, services, treatments, and therapies for each resident. Staff would also document other important and pertinent information related to each resident. When medications, services, treatment, or therapies are not performed per the service agreement and schedule, staff must document the reason why it was not performed or administered. No further information was provided.	{0 730}		

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{0 800}	Continued From page 48	{0 800}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar 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.	{0 810}		

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{0 810}	Continued From page 49 (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 required.	{0 810}		
{0 900} SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has	{0 900}		

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{0 900}	Continued From page 50	{0 900}		

been signed.
(d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.
(e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.
(f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for three of six residents (R2, R4. R9).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R2
R2 was admitted on November 8, 2018, and began receiving services under the Assisted Living with Dementia Care license on August 1, 2021.

R2's record lacked an assisted living contract.

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{0 900}	Continued From page 51 On January 30, 2023, at 11:47 a.m. regional nurse specialist (RNS)-E stated the licensee contract was "being reviewed by the third attorney. One we get back from attorney we will put out and have everyone sign". On February 2, 2023, at 9:05 a.m. community director (CD)-V verified R2's record lacked an assisted living contract. R4 R4 was admitted on August 25, 2017, and began receiving services under the Assisted Living with Dementia Care license on August 1, 2021. R4's record record included an Occupancy Agreement dated October 3, 2020, however R4's record lacked an assisted living contract. On January 30, 2023, at 11:47 a.m. regional nurse specialist (RNS)-E stated the licensee contract was"being reviewed by the third attorney. One we get back from attorney we will put out and have everyone sign". On February 2, 2023, at 9:30 a.m. RN-D confirmed R4's record lacked an assisted living contract. R9 R9 was admitted May 2, 2019, and began receiving services under the Assisted Living with Dementia Care license on August 1, 2021. R9's record included an Occupancy Agreement dated May 2, 2019. Additionally, her record included an incomplete/unsigned Assisted Living	{0 900}		

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{0 900}	Continued From page 52 contract dated December 21, 2022, which listed both R9 and her spouse. On February 1, 2023, at 2:00 p.m. RN-D stated the incomplete/unsigned Assisted Living contract was initiated when R9 returned to the facility from a hospitalization and short term nursing home stay for rehabilitation (date was not disclosed). R9 returned to the facility on December 21, 2022, when R9 and her spouse moved to an apartment in an area of the facility for residents with higher medical needs. RN-D stated the contract needed to be redone and be issued for each resident separately. No further information was provided.	{0 900}		
{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 transferred or have housing or	{0 920}		

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services terminated or be subject to an emergency relocation;
(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 three of three residents (R1, R8, R3).

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, 2021, and renewed on August 1, 2022.

On January 30, 2023, at 11:47 a.m. regional nurse specialist (RNS)-E stated the licensee contract was "being reviewed by the third attorney. Once we get back from attorney we will put out and have everyone sign".

R1's Resident Agreement was signed August 8, 2021.

R8's Resident Agreement was signed August 20,

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{0 920}	Continued From page 54 2021. R1 and R8's contract identified on the first page Resident Agreement with "assisted living" check marked and on page 2. "important contact information" indicated "facility/assisted living licensee;" and "AL [assisted living] License No [number]: 24053". The licensee's Resident Agreement being provided to all residents, lacked accurate disclosure of the category of assisted living facility license held by the facility. On February 2, 2023, at 9:05 a.m. community director (CD)-V verified R2 and R8's records lacked signing of a new contract since previous survey exited on November 4, 2022. R3's Resident Agreement was signed July 30, 2021. R3's contract identified on page 1. Resident Agreement, included a check mark in the box next to Assisted Living and left the box next to Assisted Living with Dementia Care unchecked. R3's Resident Agreement lacked the accurate disclosure of the category of assisted living with dementia care license as held by the facility. On February 2, 2023, at 9:30 a.m. CD-V verified R3's record lacked the signing of a new contract since previous survey exited on November 4, 2022. No further information was provided.	{0 920}		

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{0 940}	Continued From page 55	{0 940}		
{0 940} SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.	{0 940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 940}	Continued From page 56 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R8, R3). 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, 2021, and renewed on August 1, 2022. On January 30, 2023, at 11:47 a.m. regional nurse specialist (RNS)-E stated the licensee contract was "being reviewed by the third attorney. Once we get back from attorney we will put out and have everyone sign". R1's Resident Agreement was signed August 8, 2021. R8's Resident Agreement was signed August 20, 2021. R1 and R8's Resident Agreements indicated on page six "12. Availability of Public Funds and Resources" the licensee participated in the Housing Support Group Residential Housing Program which provided rental assistance to qualified individuals and participated in certain	{0 940}		

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{0 940}	Continued From page 57 Home and Community-Based Service Waiver programs through the Minnesota Department of Human Services and through the county with which the community is located; however, the licensee's Resident Agreement lacked the following required content: -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; The licensee's Resident Agreement being provided to all residents lacked the above content. On February 2, 2023, at 9:05 a.m. community director (CD)-V verified R2 and R8's records lacked signing of a new contract since the previous survey was exited on November 4, 2022. R3 R3's Resident Agreement was signed July 30, 2021. R3's Resident Agreement indicated on page six "12. Availability of Public Funds and Resources" the licensee participated in the Housing Support Group Residential Housing Program which provided rental assistance to qualified individuals and participated in certain Home and Community-Based Service Waiver programs through the Minnesota Department of Human Services and through the county with which the community is located; however, the licensee's Resident Agreement lacked the following required content: -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the	{0 940}		

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{0 940}	Continued From page 58 housing support program, and if so, the length of time that private payment is required; On February 2, 2023, at 9:30 a.m. CD-V verified R3's record lacked signing of a new contract since previous survey exited on November 4, 2022. No further information was provided.	{0 940}		
{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	{0 950}		

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{0 950}	Continued From page 59 right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to designated representative on a document separate from the contract and failed to ensure the contract included required content for three of three residents (R1, R8, R3). 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, 2021, and renewed on August 1, 2022. On January 30, 2023, at 11:47 a.m. regional nurse specialist (RNS)-E stated the licensee contract was "being reviewed by the third attorney. Once we get back from attorney we will put out and have everyone sign". R1's Resident Agreement was signed August 8, 2021. R8's Resident Agreement was signed August 20, 2021.	{0 950}		

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{0 950}	Continued From page 60 R1 and R8's record lacked evidence in writing of providing the verbatim notice "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 a document separate from the contact as required. The licensee lacked providing residents the verbatim notice as required for the above content. On February 2, 2023, at 9:05 a.m. community director (CD)-V verified R2 and R8 were not provided the verbatim notice since previous survey exited on November 4, 2022. R3 R3's Resident Agreement was signed July 30, 2021. R3's record lacked evidence in writing of providing the verbatim notice "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	{0 950}		

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{0 950}	Continued From page 61 care power of attorney ("health care agent"), if applicable." on a document separate from the contact as required. On February 2, 2023, at 9:30 a.m. CD-V verified R3 was not provided the verbatim notice since the previous survey was exited on November 4, 2022. No further information was provided.	{0 950}		
{0 970} SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 42 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	{0 970}		

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{0 970}	Continued From page 62 the residents). The findings include: The licensee had an assisted living with dementia care license effective August 1, 2021, and renewed on August 1, 2022. On January 30, 2023, at 11:47 a.m. regional nurse specialist (RNS)-E stated the licensee contract was "being reviewed by the third attorney. In the meantime we are crossing out waiver of liability. Once we get back from attorney we will put out and have everyone sign". R1's Resident Agreement was signed August 8, 2021. R8's Resident Agreement was signed August 20, 2021. R1 and R8's Resident Agreements included the following: -page 16. 33. Indemnification "as a resident of the community, resident assumes the risk for resident's own safety and for the safety of resident's guests and agents. Resident will indemnify and hold harmless the community, its employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the community's property, or caused wholly or in part by and act or omission of resident or resident's guests or agents." -page 16. 35. Liability "the community is not liable to resident or resident's guests for any injury,	{0 970}		

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{0 970}	Continued From page 63 death, or property damage occurring in the apartment or on the community's premises unless such injury, death or property damage occurs as the result to community's own negligent acts or those of its employees, officers, managers, owners or agents. The community is also not liable for any injury, death or damage occurring as the result of resident's receipt of health-related, supportive or other services from third-party providers. Unless caused by one of the aforementioned excepted reasons, resident agrees to hold the community harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the apartment or on the community's premises." On February 2, 2023, at 9:05 a.m. community director (CD)-V verified R2 and R8's records lacked signing of a new contract since previous survey exited on November 4, 2022. R3 R3's Resident Agreement was signed July 30, 2021. The Resident Agreement included the following: -page 16. 33. Indemnification "as a resident of the community, resident assumes the risk for resident's own safety and for the safety of resident's guests and agents. Resident will indemnify and hold harmless the community, its employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the community's property, or caused wholly or in part by and act or omission of resident or resident's guests or agents."	{0 970}		

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{0 970}	Continued From page 64 -page 16. 35. Liability "the community is not liable to resident or resident's guests for any injury, death, or property damage occurring in the apartment or on the community's premises unless such injury, death or property damage occurs as the result to community's own negligent acts or those of its employees, officers, managers, owners or agents. The community is also not liable for any injury, death or damage occurring as the result of resident's receipt of health-related, supportive or other services from third-party providers. Unless caused by one of the aforementioned excepted reasons, resident agrees to hold the community harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the apartment or on the community's premises." On February 2, 2023, at 9:30 a.m. community director (CD)-V verified R's record lacked the signing of a new contract since the previous survey exited on November 4, 2022. No further information was provided.	{0 970}		
{01350} SS=D	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the	{01350}		

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{01350}	Continued From page 65	{01350}		

licensee failed to ensure supplemental staff met all requirements for personnel employed by the licensee for one of one supplemental unlicensed personnel (ULP-U).

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

The findings include:

During the entrance conference on January 30, 2023, at 11:47 a.m. community director (CM)-V stated the licensee was utilizing staff from a supplemental staffing agency to maintain staffing at the facility.

On January 31, 2023, at 7:54 a.m. ULP-U was observed to assist R2 with dressing and grooming.

On January 31, 2023, at 6:35 a.m. ULP-U stated she had not received any orientation or training and competency from any nurse of the licensee. ULP-U stated, "Just aides do orientation, no one else showed me anything, just aides". ULP-U stated, "other aides showed me around the facility". ULP-U stated she worked in the facility prior to today, "once in a while".

On January 31, 2023, at 8:11 a.m. the surveyor asked CD-V for ULP-U's employee file the licensee had on file. CD-V stated, "[licensed practical nurse (LPN)-W] would have that".

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{01350}	Continued From page 66 ULP-U employee record contained Floor Lift Transfer (utilizing a mechanical lift) and oxygen saturation training indicating education and observation of competency was completed. The sheet was signed by LPN-W and ULP-U, with date of signatures January 5, 2023. On January 31, 2023, at 9:23 a.m. the surveyor showed ULP-U documented information in ULP-U's record. ULP-U stated, "the nurse [LPN-W] had me sign today and write the date of January 5, 2023," for the date of signature. ULP-U stated,"the aide went over some of the information" in the record prior to today. ULP-U stated, "The nurse went over it with me today". On January 31, 2023, at 9:25 a.m. LPN-W stated she had ULP-U backdate information in ULP-U's record today for the date of January 5, 2023. LPN-W stated, "I did delegated task training and competency with [ULP-U]". LPN-W stated ULP-U "had no training or competency with an RN". ULP-U's record lacked documented evidence the licensee had trained and determined ULP-U was competent for delegated tasks of EZ stand lift, Hoyer lift, oximeter (used to measure pulse and oxygen level) and automatic blood pressure wrist cuff. On February 1, 2023, at 12:28 p.m. CD-V stated regarding LPN-W having ULP-U back date documents, "we don't do that, not our practice". CD-V stated, "when training done, document on the day done". At the time RN-D verified the facility utilized EZ stand lift, Hoyer lift, oximeter and automatic blood pressure wrist cuff and ULP would use the equipment.	{01350}		

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{01350}	Continued From page 67 The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations must be conducted by an RN and only unlicensed personnel who were determined competent and posses the knowledge and skills consistent with the complexity of tasks being delegated would be permitted to perform such tasks. The assisted living would have a system in place to communicate up to date information to a RN regarding current available staff and their competencies. The licensee Temporary and Contracted Staff policy dated August 1, 2021, indicated temporary supplemental staffing would only be used if they meet the same requirements required as hired employees and would be treated as if they were staff of the facility. Competency evaluation results must be obtained for unlicensed personnel who would be assigned to perform delegated nursing services. Staff must be orientated tot he individual needs of each assigned resident, the service plan, methods of documentation, and other elements required to provide safe home care services. No further information was provided.	{01350}		
{01370} SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne	{01370}		

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{01370}	Continued From page 68 pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure three of five unlicensed personnel (ULP-H, ULP-J, ULP-T) completed training prior to providing direct cares as required.	{01370}		

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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
{01370}	Continued From page 69 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: ULP-H ULP-H's date of hire was October 4, 2022. ULP-H provided direct care and services to the licensee residents. ULP-H's record lacked evidence the following education had been completed prior to providing direct cares: -medication, exercise, and treatment reminders ULP-J ULP-J had a hire date of March 1, 2022. ULP-J provided direct care and services to the licensee residents. On January 31, 2023, at 8:34 a.m. ULP-J was observed to administer medications to R1, check R1's blood pressure, check R1's blood sugar and applied knee high TED (thrombo embolic deterrent) stockings (used to reduce swelling) to R1's lower legs/feet. ULP-J's record lacked evidence the following education had been completed prior to providing direct cares: -medication, exercise, and treatment reminders	{01370}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24053	A. BUILDING: _____ B. WING _____	R 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

(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
{01370}	Continued From page 70 On February 1, 2023, at 12:28 a.m. community director (CD)-V, registered nurse (RN)-D and administrative assistant (AA)-X stated they "would look for" the training for ULP-H and ULP-J; however, no further information was provided. On February 2, 2023, at 8:56 a.m. RN-D and operations specialist (OS)-Y stated they "gave employee information found, if not in there, don't have". ULP-T ULP-T had a hire date of October 4, 2022, and provided direct care and services to the licensee's residents. ULP-T's record lacked evidence the following education had been completed prior to providing direct cares: -medication, exercise, and treatment reminders -recognizing physical, emotional, cognitive, and developmental needs of the client. On February 2, 2023, at 8:56 a.m. RN-D and OS-Y stated they "gave employee information found, if not in there, don't have". The licensee's Competency Training Evaluations policy (5.02) dated August 1, 2021, indicated training and competency evaluations for all ULP would include, medication, exercise and treatment reminders. No further information provided.	{01370}		
{01380} SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and	{01380}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
{01380}	Continued From page 71 competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure five of five unlicensed personnel (ULP-H, ULP-J, ULP-S, ULP-N, ULP-T) completed training and competency evaluations prior to providing direct cares as required. 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: ULP-H	{01380}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{01380}	Continued From page 72 ULP-H's date of hire was October 4, 2022. ULP-H provided direct care and services to the licensee residents. ULP-H's record lacked evidence the following education and/or competency evaluation had been completed prior to providing direct cares: -training and competency for delegated tasks of CPAP (continuous positive airway pressure)/BiPAP (bilevel positive airway pressure) equipment, oxygen use, oxygen saturation utilizing a pulse oximetry device, and wrist blood pressure cuff. ULP-J ULP-J had a hire date of March 1, 2022. ULP-J provided direct care and services to the licensee residents. On January 31, 2023, at 8:34 a.m. ULP-J was observed to administer medications to R1, check R1's blood pressure, check R1's blood sugar and applied knee high TED (thromboembolic deterrent) stockings (used to reduce swelling) to R1's lower legs/feet. ULP-J's record lacked evidence the following education and competency evaluation had been completed for delegated tasks prior to providing direct cares: -CPAP/BiPAP equipment -oxygen saturation utilizing a pulse oximetry device -wrist blood pressure cuff ULP-S ULP-S had a hire date of August 22, 2017. ULP-S provided direct care and services to the licensee residents.	{01380}		

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{01380}	Continued From page 73 On January 30, 2023, at 11:00 a.m. ULP-S was observed to administer medication to R11 and R12. ULP-S's record lacked evidence the following education and competency evaluation had been completed for delegated tasks prior to providing direct cares: -wrist blood pressure cuff On February 1, 2023, at 12:28 a.m. community director (CD)-V, registered nurse (RN)-D and administrative assistant (AA)-X stated they "would look for" the training for ULP-H, ULP-J and ULP-S. On February 2, 2023, at 8:56 a.m. RN-D and operations specialist (OS)-Y stated they "gave employee information found, if not in there, don't have". ULP-N ULP-N was hired on October 4, 2022, to provide assisted living services. ULP-N's training record lacked evidence of training with treatments to include: -CPAP/Bipap - oxygen - oxygen saturations using pulse oximetry device - wrist blood pressure cuffs ULP-T ULP-T had a hire dated of October 4, 2022. ULP-T provided direct care and services to the licensee's residents. On January 30, 2023, ULP-T was observed to provide a blood glucose check to R9 while in her apartment.	{01380}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{01380}	Continued From page 74 ULP-T's record lacked evidence the following education and competency evaluation had been completed for delegated tasks prior to providing direct cares: -oxygen -oxygen saturation utilizing a pulse oximetry device -wrist blood pressure cuff On February 2, 2023, at 8:56 a.m. RN-D and OS-Y stated they "gave employee information found, if not in there, don't have". The licensee's Competency Training Evaluations policy (5.02) dated August 1, 2021, read,when a registered nurse or licensed health professional staff of (corporate name) delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. Additionally, training and competency evaluation for unlicensed personnel provided assisted living services must include administering medications or treatments as required. No further information provided.	{01380}		
{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	{01440}		

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{01440}	Continued From page 75 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 thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date in which the individual began working for the facility for two of three unlicensed personnel (ULP-J, ULP-T). 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:	{01440}		

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{01440}	Continued From page 76 ULP-J ULP-J had a hire date of March 1, 2022. On January 31, 2023, at 8:34 a.m. ULP-J was observed to administer medications to R1, check R1's blood pressure, check R1's blood sugar and applied knee high TED (thromboembolic deterrent) stockings (used to reduce swelling) to R1's lower legs/feet. ULP-J's record included "Supervision of Personnel" sheet dated March 31, 2022; however, the supervision lacked documented evidence of observation of a delegated task by the RN. ULP-J's employee record lacked documented evidence of a registered nurse (RN) supervising ULP-J performing delegated tasks. On February 1, 2023, at 12:28 a.m. community director (CD)-V, RN-D and administrative assistant (AA)-X stated they "would look for" more information for the supervisory visit for ULP-J. RN-D verified ULP-J's "Supervision of Personnel" sheet dated March 31, 2022, lacked documented evidence of observation of a delegated task by the RN. On February 2, 2023, at 8:56 a.m. RN-D and operations specialist (OS)-Y stated they "gave employee information found, if not in there, don't have". ULP-T had a hire date of October 4, 2022, and was providing direct care and services for the licensee's residents. On January 30, 2023, at 9:20 a.m. ULP-T was	{01440}		

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{01440}	Continued From page 77 observed to provide a blood glucose check to R9 while in her apartment. ULP-T's record included "Supervision of Personnel" dated January 18, 2023; however, the document was signed by the licensee's licensed practical nurse (LPN)-W. The document included skills observed to include: -Staff clean and dressed appropriately -Communication/rapport with resident -Respect and dignity for resident/or family -Accurate documentation -Infection Control/standard precautions followed -Med [medication] administration: 3 [three] checks completed -hand hygiene before/after administering and before documentation LPN-W had indicated ULP-T's performance met or exceeded standards in each of the above listed skills. The licensee failed to ensure a RN provided direct supervision/observation for ULP-T, and a delegated task. On January 31, 2023, at 12:30 p.m. LPN-W stated, "I am not doing the 30 day supervision, I only chatted with [ULP-T] and made notes to help the RN. I absolutely did not do the supervision. She [ULP-T] will not have a 30 day supervision done by the RN." The licensee's Supervision of Staff Delegated Services dated August 1, 2021, indicated staff who provide delegated nursing or therapy tasks to residents would be supervised by an RN and would include observation of the staff administering the medication or treatment and the	{01440}		

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{01440}	Continued From page 78 interaction with the resident. No further information was provided.	{01440}		
{01460} SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of three unlicensed personnel (ULP-U) received orientation to assisted living facility licensing requirements and regulations before providing services. 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-U	{01460}		

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{01460}	Continued From page 79 During the entrance conference on January 30, 2023, at 11:47 a.m. community director (CD)-V stated the licensee was utilizing staff from a supplemental staffing agency to maintain staffing at the facility. On January 31, 2023, at 7:54 a.m. ULP-U was observed to assist R2 with dressing and grooming. ULP-U's records lacked evidence of receiving orientation to assisted living before providing services to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	{01460}		

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{01460}	Continued From page 80 other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On January 31, 2023, at 6:35 a.m. ULP-U stated she had not received any orientation or training and competency from any nurse of the licensee. ULP-U stated, "Just aides do orientation, no one else showed me anything, just aides". ULP-U stated, "other aides showed me around the facility". ULP-U stated she worked in the facility prior to today, "once in a while". On January 31, 2023, at 8:11 a.m. the surveyor asked CD-V for ULP-U's employee record the licensee had on file. CD-V stated, "[licensed practical nurse (LPN)-W] would have that". ULP-U's employee record contained New Agency Orientation Guideline signed by ULP-U and LPN-W, with date of signatures January 5, 2023, which included some topics for emergency training. On January 31, 2023, at 9:23 a.m. the surveyor showed ULP-U documented information in ULP-U's record. ULP-U stated, "the nurse [LPN-W] had me sign today and write the date of January 5, 2023" for the date of signature. ULP-U stated,"the aide went over some of the information" in the record prior to today. ULP-U stated, "The nurse went over it with me today". On January 31, 2023, at 9:25 a.m. LPN-W stated she had gone over the New Agency Orientation Guideline with ULP-U "today" and had ULP-U backdate the date for the date of January 5, 2023.	{01460}		

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{01460}	Continued From page 81 On February 1, 2023, at 12:28 p.m. CD-V stated regarding LPN-W having ULP-U back date documents, "we don't do that, not our practice". CD-V stated, "when training done, document on the day done". The licensee Temporary and Contracted Staff policy dated August 1, 2021, indicated temporary supplemental staffing would only be used if they meet the same requirements required as hired employees and would be treated as if they were staff of the facility. Competency evaluation results must be obtained for unlicensed personnel who would be assigned to perform delegated nursing services. Staff must be orientated tot he individual needs of each assigned resident, the service plan, methods of documentation, and other elements required to provide home care services. The licensee's Orientation of Staff and Supervisors and Content policy dated August 1, 2021, indicated all staff of the licensee providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. Orientation must be completed once for each staff person and is not transferable to another home care provider. No further information was provided.	{01460}		
{01540} SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working	{01540}		

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{01540}	Continued From page 82	{01540}		

hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure direct care staff completed the required amount of dementia care training in the required time frame for two of five employees (unlicensed personnel (ULP)-H, ULP-U).

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-H
ULP-H date of hire was October 4, 2022, provided direct care to residents under the licensee's Assisted Living with Dementia Care

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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
{01540}	Continued From page 83 license. ULP-H's record included the following certificates of completed dementia training topics: -activities for individuals living with Alzheimer's disease dated November 1, 2022, (one hour of education training) -principles of person centered planning dated October 5, 2022, (no time documented) -helping prevent client elopement dated October 9, 2022, (one hour) ULP-H's record lacked documented evidence of required training for required topics of an explanation of Alzheimer's disease and other dementia's; Assistance with activities of daily living; Problem solving with challenging behaviors; Communication skills and evidence a total of eight (8) hours of training was completed within 80 hours of employment start date. ULP-U During the entrance conference on January 30, 2023, at 11:47 a.m. community director (CD)-V stated the licensee was utilizing staff from a supplemental staffing agency to maintain staffing at the facility. On January 31, 2023, at 7:54 a.m. ULP-U was observed to assist R2 with dressing and grooming. ULP-U's records lacked documented evidence of required training for the areas of an explanation of Alzheimer's disease and other dementia's; assistance with activities of daily living; problem solving with challenging behaviors; communication skills; person-centered planning and service delivery and evidence a total of eight (8) hours of training was completed within 80	{01540}		

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{01540}	Continued From page 84	{01540}		

hours of employment start date.

On January 31, 2023, at 6:35 a.m. ULP-U stated she had not received any orientation or training and competency from any nurse of the licensee. ULP-U stated, "Just aides do orientation, no one else showed me anything, just aides". ULP-U stated, "other aides showed me around the facility". ULP-U stated she worked in the facility prior to today, "once in a while".

On January 31, 2023, at 8:11 a.m. the surveyor asked CD-V for ULP-U's employee record the licensee had on file. CD-V stated, "[licensed practical nurse (LPN)-W] would have that".

On January 31, 2023, at 9:25 a.m. LPN-W stated ULP-U did not receive any training for dementia. LPN-W stated she provided ULP-U some reading material for dementia, but ULP-U "has not read yet".

On January 31, 2023, at 12:30 p.m. CD-V stated she had "no other dementia training" for ULP-H. CD-V stated the "training has been assigned" for ULP-H to complete.

The licensee Temporary and Contracted Staff policy dated August 1, 2021, indicated temporary supplemental staffing would only be used if they meet the same requirements required as hired employees and would be treated as if they were staff of the facility. Staff must be orientated to the individual needs of each assigned resident, the service plan, methods of documentation, and other elements required to provide home care services.

The licensee's Dementia Training policy (5.03) dated August 1, 2021, indicated direct care

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{01540}	Continued From page 85 employees would complete eight (8) hours of initial training within 80 hours of the employment start date. No further information was provided.	{01540}		
{01620} SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in 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	{01620}		

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{01620}	Continued From page 86	{01620}		

documented a comprehensive assessment for 90-day reassessment and monitoring and comprehensive reassessment for change in condition for four of six residents (R8, R3, R4, R9).

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:

R8
R8's diagnoses included fluid overload (too much fluid in the body), chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing) and hypertension (abnormally high blood pressure).

R8's service plan/care plan dated August 31, 2020, indicated R8 received services including activities, pain, risk of choking monitoring, bathing, dressing/undressing, meals, medication administration, treatments: CPAP/TED (thrombo embolic deterrent) stockings/weights/vitals, toileting assist, lotion feet after shower, wheelchair assistance long distances, Mobility assistance, visual checks for safety, assistance with emergency situations, fall interventions, daily bed making/room tidy, housekeeping, laundry, trash removal and linen changes.

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{01620}	Continued From page 87 On January 31, 2023, at 6:35 a.m. ULP-U stated R8 was already awake and dressed. ULP-U stated she set up R8's toothbrush and he brushed his teeth, assisted R8 to shave, wash face, change incontinent product, dress and put on R8's TED stockings. 90 DAY COMPREHENSIVE ASSESSMENT The licensee failed to ensure 90-day resident reassessment and monitoring was comprehensive. R8's 90-day Review dated November 26, 2022, included a review of diagnoses, recap of health status since the last review, progress on previous recommendations, are orders current, nurse has reviewed all medications (adverse side effects, effectiveness, indications of use, side effects, contraindications, allergies, adverse reactions or concerns of diversion of medications, storage), changes in activities of daily living (ADL) listed on the "ISP" (individual service plan) since last review, services reviewed as per service plan. R8's 90-day review as above, lacked inclusion of required areas of the uniform assessment tool (comprehensive assessment) and documented evidence of a physical assessment by the RN. CHANGE IN CONDITION COMPREHENSIVE ASSESSMENT R8's record lacked comprehensive assessment by the RN for change in condition related to development of pressure ulcer. R8's physician Progress Notes dated January 24, 2023, included pressure ulcer of right hip stage 2. On exam pressure ulcer measuring 5 cm (centimeters) x 6.5 cm over the right trochanteric area. Vesicles had been present that are now	{01620}		

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broken open. Granulating tissue in wound bed. Area is slightly erythemic (reddening of the skin), no purulent drainage (a sign of infection), no odor. Provided written orders for the facility to wash the wound with soap and water before changing the dressing. To change the dressing every Monday, Wednesday, and Friday. To inspect the wound for infection and report concerns. To help the patient reposition and off load pressure by avoiding sleeping on his right side at night.

R8's Progress Notes included the following:
-January 24, 2022, documented by licensed practical nurse (LPN)-W, resident assistant (RA) "was doing morning cares with resident and noted a sore on right hip. RA notified CNP [certified nurse practitioner] who was in the room to see the resident. Resident stated his right hip was hurt for about two to three weeks. CNP notified this writer and we noted stage 2 pressure sore 1" X 2" over the right trochanteric area. Vesicles had been present that are now broken open. Granulation tissue in wound bed. Area is slightly erythemic, no purulent drainage and no odor notes. Area covered with foam dressing. Dressing will be changed every three days by nurse with Mepilex border dressing."

R8's record lacked documented evidence an RN was notified of the change in condition for R8, including comprehensive reassessment and monitoring by a RN for change in condition related to development of a stage 2 pressure wound.

On February 2, 2023, at 9:05 a.m. RN-D stated she had completed a comprehensive assessment on R8 "on Tuesday" (January 31, 2023). RN-D reviewed R8's record and verified there was no

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documented evidence in R8's record an RN had been notified of the change in condition for R8. RN-D stated the RN she would ask "was on vacation" and she did not know if the RN was made aware. RN-D provided the assessment she completed on January 31, 2023, for R8. The assessment indicated "tight trochanter (hip) resident has a stage 2 pressure injury that measures 3 cm (high) x 5 cm (long) with a noted blister to the wound bed. Mepilex dressing ordered 3x/[times per]week."

On February 2, 2023, at 9:05 a.m. regional nurse specialist (RNS)-E stated the licensee's 90 day review for comprehensive assessment was a shortened version of the licensee's comprehensive assessment.

R3
R3's diagnoses included heart failure, atrial flutter on coumadin (blood thinner to prevent blood clots), peripheral vascular disease (a condition where there is poor blood circulation to extremities), chronic kidney disease, benign prostatic hyperplasia with urinary retention and lower urinary tract symptoms (enlarged prostate causing poor bladder emptying), presence of suprapubic urinary stoma/catheter (opening to the bladder through the abdomen for urinary catheter placement), polyosteoarthitis (multiple locations of arthritis).

R3's service plan/care plan indicated last service plan review completed January 13, 2023, indicated R3 received services that included bathing assistance, daily lower extremity compression wrap assistance, suprapubic catheter site care and catheter bag management,

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skin checks, medication administration, dressing cues with some hands-on assistance, visual checks every shift, housekeeping, and laundry. Resident receives wound care and INR (international normalized ratio/lab calculation based on prothrombin test results; a test measuring how long it takes a blood clot to form in a blood sample) by an outside agency.

On January 31, 2023, at 7:00 a.m. ULP-Q was observed to provide oral medications, topical cream to feet, compression wraps to both lower extremities, suprapubic catheter site care, urinary bag maintenance and exchange, light sponge bath, and dressing assistance. Two dressings were observed on R3's right foot. ULP-Q stated the wound care was completed by a home health agency and the ULP do not do anything with the dressings.

R3's Comprehensive -V2 assessment dated January 12, 2023, page eight, number five. Skin Concerns: diagram of front and backside of body with numbers to identify areas of wounds/skin concerns. A table beneath this diagram included: Site; 49) Right heel, 50) Left heel, 51) Right toe(s), 52) Left toe(s). The table indicated an area labeled "Description" but lacked a description or measurements of any of the noted wounds/skin concerns. 6. Has the resident had any skin alterations in the last 90 days? selection a. indicated "yes". 7. Comments: "Ulcers on L [left] heel and toes managed by [home health care and vascular clinic]."

R3's Progress Notes included the following entries:
-January 13, 2023, at 2:09 p.m. read Resident seen face to face for annual assessment. He is calm and cooperative He receives a lot of help

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with ADL [activities of daily living] already at this time. No new services are seen to be needed. A resident has no concerns about his plan of care, called POA (power of attorney) the nephew and he also has no concerns in regard to cares. ISP is appropriate and verbal phone consent was received from (POA).
-January 13, 2023, at 2:49 p.m. read Resident seen by (home health agency) nurse today wounds are stable, WC [sic] nurse pushing for family to visit the good feet store to purchase better shoes for him. RA to be mindful about placing wraps the proper way. No new concerns at this time.
-January 16, 2023 at 3:19 p.m. read RA reported that the resident has an open area on his bottom they discovered while bathing. Resident is refusing toileting help and told nursing to "come back later" Nursing will revisit tomorrow to assess skin break down.
-January 18, 2023, at 1:59 p.m. read Resident's INR 1.8 - no changes to warfarin order and recheck in 2 [two] weeks. Wound care complete no concerns noted.
-January 25, 2023, at 1:40 p.m. read (home health agency) wound cares complete. No concerns or new areas of concerns noted.
-January 27, 2023, at 1:27 p.m. read (home health agency) did wound care, no concerns.

The licensee failed to complete a full assessment of R3's foot wounds to include a description and measurements in the licensee's comprehensive assessment, and failed to follow up and assess the newly reported wound on R3's bottom.

On February 2, 2023, at 9:20 a.m. RN-D stated, "I'm not sure anyone else discussed the wound on his [R3's] bottom. We do not manage any wound care here, but have an outside home

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health agency take care of any wound care needs. We will follow up with [home health agency] regarding this wound." Regarding the need to include more information in the comprehensive assessment by the licensee's nurse, RN-D stated, "I will make note of this and have the RN's be aware of this."

R4
R4's diagnoses include unspecified dementia, psychotic disturbance (history of hallucinations), mood disturbance and anxiety, depression, age related osteoporosis (brittle/weak bones susceptible to fractures) with history of second lumbar vertebra compression fracture, asthma, dry eyes, hypertension (high blood pressure) and hypothyroidism (a condition with poor thyroid gland function).

R4's service plan/care plan dated November 1, 2022, indicated R4 received services to include medication management, weekly bathing/showering/sponge bath assistance, grooming/oral hygiene, assistance with glasses and hearing aids, dressing assistance/cues, assistance each morning and evening with TED stockings, ace wrap to lower right extremity as needed, eating encouragement, cues to use walker, safety checks (eight times per shift), toileting assistance, escort to and from dining area and activities, housekeeping, laundry and housekeeping. Additionally, R4 began receiving hospice services on August 30, 2022.

On January 31, 2023, at 2:00 p.m. ULP-Q stated R4 was currently resting in bed, staff continued to provide all personal cares, and stated R4 no longer wore her TED (thromboembolic deterrent) stockings .

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{01620}	Continued From page 93 R4's 90-day Review dated November 3, 2022, included a review of diagnoses, recap of health status since last review, progress on previous recommendations, are orders current, nurse has reviewed all medications (adverse side effects, effectiveness, indications of use, side effects, contraindications, allergies, adverse reactions or concerns of diversion of medications, storage), changes in activities of daily living (ADL) listed on the "ISP" (individual service plan) since last review, services reviewed as per service plan. R4's 90-day review as above, lacked inclusion of required areas of the uniform assessment tool (comprehensive assessment) and documented evidence of a physical assessment by the RN. On February 2, 2023, at 9:05 a.m. RNS-E stated the licensee's 90 day review for comprehensive assessment was a shortened version of the licensee's comprehensive assessment. R9 FALL ASSESSMENT R9's diagnoses included type two diabetes, Parkinson's disease (a progressive disorder that affects the nervous system and parts of the body controlled by the nerves), depression, anxiety, and heart failure. R9's unsigned Service Plan dated January 17, 2023, indicated she received services to include medication administration, blood glucose checks, assistance with transfers, showers, dressing, and toileting, and visual safety checks. On January 30, 2023, at 9:20 a.m. ULP-T was observed to provide a blood glucose check to R9 while in her apartment.	{01620}		

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R9's Incident report dated January 1, 2023, included Incident Description; Nursing Description: Resident was reaching for something in her closet and slid out of her w/c [wheelchair] on to the floor. Resident used call pendant to call RA (resident assistant). Resident Description: Resident stated she slide [sic] out of her w/c while reaching for something in the closet.
Immediate Action Taken; Description: RA was alerted by call pendant to resident's room and observed resident on the floor in front of her w/c. on call nurse called and assessed over the phone. Resident was a&o [alert and oriented], denies LOC (loss of consciousness) or hitting her head. Noted a cut on top of resident's left hand by the knuckle and between finger. RA noted cut was "kind of deep". RA will clean up wound and cover with gauze and Kerlix wrap. 2 (two) staff used Mechanical lift to assist resident into her w/c. RA reminded resident to extension grabber or ask husband for help or used call pendant to ask RA for help. ROM (range of motion) good, denies pain. VSS (vital signs) RA instructed to call nurse back with any changes.
Injuries observed at time of incident-Injury type: Laceration, Injury Location: 30) Left hand (back)

R9's Progress note dated January 1, 2023, at 2:15 p.m. documented by LPN-W, read Note Text: RA was called to residents apartment via call pendant. RA observed resident on the floor in front of her w/c. Resident stated she was trying to reach for something in the closet and slid out of her w/c. Denis [sic] pain or discomfort, denies hitting her head or LOC, A & 0. ROM good -VS (vital signs): BP (blood pressure)104/66 -P(pulse) 78 -T(temperature) 96.3 - SpO2 (blood oxygen saturation level) @ 95% RA (room air).
RA noted a laceration on top of left hand between the knuckle and forefinger. RA was instructed to

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{01620}	Continued From page 95 clean up the laceration, cover with gauze and Kerlix wrap. Resident was assisted off the floor into her w/c via mechanical lift with 2 assist. Family and physician notified. Staff will continue to monitor. The licensee failed to complete a face to face assessment with R9's fall with an injury. On February 2, 2023, at 10:45 a.m. regarding how the licensee follows up with resident falls, RN-D stated, "We completed a face to face follow up within 24 hours to assess the injury and act accordingly." Regarding a nurse follow up face to face for R9's fall on January 1, 2023, where R9 sustained a cut to her hand, RN-D stated, "no full assessment was completed, no." The licensee's Assessments, Reviews and Monitoring policy (6.01) dated August 1, 2021, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated and signed by the registered nurse who conducted the assessment. Resident reassessment and monitoring must be conducted no more than 14 calendar days after the 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. Quarterly assessments, not exceeding 90 calendar days, may be performed by a licensed practical nurse as a focused assessment if no resident changes are noted. The individualized review or subsequent reviews must include all the required elements as specified in Rule, conducted in person, be in	{01620}		

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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
{01620}	Continued From page 96 writing, dated and signed by the registered nurse who conducted the individualized review. No further information was provided	{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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident service plan included a signature or other authentication by the resident and the licensee to document the agreement on the services to be provided and/or failed to ensure revision of the	{01640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24053	A. BUILDING: _____ B. WING _____	R 02/02/2023

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ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01640}	Continued From page 97 service plan with changes in service for three of five residents (R2, R8, R9). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's record lacked documented evidence of signature or other authentication by the resident and the licensee for revision of service plan. R2's diagnoses included Alzheimer's disease. R2's last service plan/care plan was signed by a RN on January 8, 2021, and R8's family member on December 8, 2021. R2's service plan/care plan indicated the last service plan review was completed January 19, 2023, and identified a change in service for toileting "assistance needed to use toilet and maintain bladder continence; has history of UTI's [urinary tract infection]. Monitor for signs and symptoms such as pain, frequency, burning, foul odor, incontinence, dizziness, weakness, or confusion. Report change to RN. If these symptoms occur encourage fluid. Is continent of bowels. Is incontinent of bladder. Reminders/cues to use toilet for voiding overnight."	{01640}		

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{01640}	Continued From page 98 The service plan/care plan dated January 19, 2023, lacked documented evidence of signature or other authentication by the resident and the licensee for change in service. On February 2, 2023, at 9:05 a.m. RN-D stated R2's progress note dated January 19, 2023, read R2's family was contacted for review of R8's service plan, "but doesn't say updated". RN-C stated when there are changes we "call and discuss updates, therefore should get a signature." R8 R8's diagnoses included fluid overload (too much fluid in the body), chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing) and hypertension (abnormally high blood pressure). R8's service plan/care plan dated August 31, 2020, indicated R8 received services including activities, pain, risk of choking monitoring, bathing, dressing/undressing, meals, medication administration, treatments: CPAP/TED stockings/weights/vitals, toileting assist, lotion feet after shower, wheelchair assistance long distances, Mobility assistance, visual checks for safety, assistance with emergency situations, fall interventions, daily bed making/room tidy, housekeeping, laundry, trash removal and linen changes. On January 31, 2023, at 6:35 a.m. ULP-U stated R8 was already awake and dressed. ULP-U stated she set up R8's toothbrush and he brushed his teeth, assisted R8 to shave, wash face, change incontinent product, dress and put on R8's TED stockings.	{01640}		

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{01640}	Continued From page 99	{01640}		

R8's Progress Notes included the following:
-January 24, 2022, documented by LPN-W, resident assistant (RA) "was doing morning cares with resident and noted a sore on right hip. RA notified CNP [certified nurse practitioner] who was in the room to see the resident. Resident stated his right hip was hurt for about two to three weeks. CNP notified this writer and we noted stage 2 pressure sore 1" X 2" over the right trochanteric area. Vesicles had been present that are now broken open. Granulation tissue in wound bed. Area is slightly erythemic, no purulent drainage and no odor notes. Area covered with foam dressing. Dressing will be changed every three days by nurse with Mepilex border dressing."

R8's service plan lacked revision for services of wound dressing changes by the licensee's nursing staff.

On February 2, 2023, at 9:05 a.m. RN-D stated she "updated" R8's service plan when she "completed a comprehensive assessment" on R8 "on Tuesday" (January 31, 2023). RN-D reviewed R8's record and verified there was no documented evidence in R8's record an RN had been notified of the change in condition for R8.

R9
R9's diagnoses included type two diabetes, Parkinson's disease (a progressive disorder that affects the nervous system and parts of the body controlled by the nerves), depression, anxiety, and heart failure.

R9's unsigned Service Plan dated January 17, 2023, indicated she received services to include medication administration, blood glucose checks,

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{01640}	Continued From page 100 assistance with transfers, showers, dressing, and toileting, and visual safety checks. On January 30, 2023, at 9:20 a.m. ULP-T was observed to provide a blood glucose check to R9 while in her apartment. R9's unsigned Service Plan dated January 17, 2023, indicated on page nine, in section labeled Safety, Is on visual "I'm okay" checks: Once a shift. Additionally, in the same section a line which read Visual Checks every two hours. Please ask resident if she needs to use the bathroom when you check on her. She feels weak during the night when she has to get up. R9's Task documentation record dated January 2023, indicated visual checks every one hour. Please ask resident if she needs to use the bathroom when you check on her. She feels weak during the night when she has to get up. The Task documentation record indicated ULP initials to occur mostly every hour starting January 18, 2023. R9's Progress note dated January 17, 2023, at 3:52 p.m. read the resident continues to self-transfer and fell just after arriving back to the community. No injury apparent at this time. Denies head strike. Called son (name) 2x (two times), no answer and VM (voice mail) is full, unable to leave a message. R9's Service Plan dated January 17, 2023, lacked the signatures of the licensee and R9's resident representative. Additionally, the licensee failed to revise R9's Service Plan for the provision of every one hour safety checks as started on January 18, 2023.	{01640}		

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{01640}	Continued From page 101 On February 2, 2023, at 11:00 a.m. RN-D stated the RN left messages for the POA to sign the new service plan on January 17, 2023. RN-D stated the active care plan, that ULP see right away states every one hour safety checks and will be updated to R9's Service Plan. RN-D stated the safety checks previous to January 18, 2023, were four times per shift. An updated Service Plan with corrections was presented to the surveyor on February 2, 2023, at 12:30 p.m. The licensee's 6.05 Service Plan policy dated August 1, 2021, indicated "All residents receiving assisted living services will have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. A service plan means the written plan between a resident or residents designated representative and the facility about the services that will be provided to the resident. The procedure indicated within 14 days after the date that services are first provided to a resident [licensee name] will finalized a written service plan. The service plan and any revisions shall include a signature or other authentication by [licensee name] and by the resident, or resident's representative documenting agreement on the services to be provided. Service plans shall be revised, if needed, based on resident reassessments and monitoring." No further information was provided.	{01640}		
{01650} SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	{01650}		

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{01650}	Continued From page 102 (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 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 five of six residents (R2, R8, R3, R4, R9). 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	{01650}		

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{01650}	Continued From page 103	{01650}		

cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R2
R2's diagnoses included Alzheimer's disease.

R2's service plan/care plan dated January 19, 2023, lacked the following:
-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 145C, and declarations made by the resident under those chapters (living will).

On February 2, 2023, at 9:05 a.m. regional nurse specialist (RNS)-E stated the content of the above was included in the resident assisted living contract; however, R2's record lacked an assisted

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{01650}	Continued From page 104 living contract. On February 2, 2023, at 9:05 a.m. community director (CD)-V verified R2's record lacked an assisted living contract. R8 R8's diagnoses included fluid overload, chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing) and hypertension (abnormally high blood pressure). R8's service plan/care plan dated August 31, 2020, indicated R8 received services including activities, pain, risk of choking monitoring, bathing, dressing/undressing, meals, medication administration, treatments: CPAP/TED stockings/weights/vitals, toileting assist, lotion feet after shower, wheelchair assistance long distances, Mobility assistance, visual checks for safety, assistance with emergency situations, fall interventions, daily bed making/room tidy, housekeeping, laundry, trash removal and linen changes. On January 31, 2023, at 6:35 a.m. ULP-U stated R8 was already awake and dressed. ULP-U stated she set up R8's toothbrush and he brushed his teeth, assisted R8 to shave, wash face, change incontinent product, dress and put on R8's TED (thrombo embolic deterrent) stockings. R8's Progress Notes included the following: -January 24, 2022, documented by licensed practical nurse (LPN)-W, resident assistant (RA) "was doing morning cares with resident and noted a sore on right hip. RA notified CNP [certified nurse practitioner] who was in the room to see	{01650}		

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{01650}	Continued From page 105	{01650}		

the resident. Resident stated his right hip was hurt for about two to three weeks. CNP notified this writer and we noted stage 2 pressure sore 1" X 2" over the right trochanteric area. Vesicles had been present that are now broken open. Granulation tissue in wound bed. Area is slightly erythemic, no purulent drainage and no odor notes. Area covered with foam dressing. Dressing will be changed every three days by nurse with Mepilex border dressing."

R8's service plan lacked revision for services of wound dressing changes by the licensee nursing staff.

R2's service plan/care plan lacked the following for providing the treatment service of wound dressing changes:
-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;
-the identification of staff or categories of staff who will provide the services;

On February 2, 2023, at 9:05 a.m. RN-D stated she "updated" R8's service plan when she "completed a comprehensive assessment" on R8 "on Tuesday" (January 31, 2023). RN-D reviewed R8's record and verified there was no documented evidence in R8's record an RN had been notified of the change in condition for R8. RN-D stated the RN she would ask was on vacation and she did not know if the RN was made aware.

R3
R3's diagnoses included heart failure, atrial flutter on coumadin (blood thinner to prevent blood clots), peripheral vascular disease (a condition

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{01650}	Continued From page 106	{01650}		

where there is poor blood circulation to extremities), chronic kidney disease, benign prostatic hyperplasia with urinary retention and lower urinary tract symptoms (enlarged prostate causing poor bladder emptying), presence of suprapubic urinary stoma/catheter (opening to the bladder through the abdomen for urinary catheter placement), polyosteoarthritis (multiple locations of arthritis).

R3's service plan/care plan indicated last service plan review completed January 13, 2023, lacked the following:
- the fees for services (all 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
(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145C, and declarations made
by the resident under those chapters (living will).

On February 2, 2023, at 9:20 a.m. RNS-E stated, "As was shared with the last survey, this information is in the lease/contract, will get an addendum sheet with breakdown of fees, after reviewed the service packet, the service plan

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{01650}	Continued From page 107 does not reference to look at the contract." R4 R4's diagnoses included unspecified dementia, psychotic disturbance (history of hallucinations), mood disturbance and anxiety, depression, age related osteoporosis (brittle/weak bones susceptible to fractures) with history of second lumbar vertebra compression fracture. R4's service plan/care plan dated November 1, 2022, indicated R4 received services to include medication management, weekly bathing/showering/sponge bath assistance, grooming/oral hygiene, assistance with glasses and hearing aids, dressing assistance/cues, assistance each morning and evening with TED stockings, ace wrap to lower right extremity as needed, eating encouragement, cues to use walker, safety checks (eight times per shift), toileting assistance, escort to and from dining area and activities, housekeeping, laundry and housekeeping. Additionally, R4 began receiving hospice services on August 30, 2022. On January 31, 2023 at 2:00 p.m. ULP-Q stated staff provided all R4's personal cares, and further stated R4 no longer wore her TED stockings. R4's record lacked an assisted living with dementia care contract that contained the following required elements of the service plan: -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: - the action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility;	{01650}		

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{01650}	Continued From page 108 - 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 - 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 February 2, 2023, at 9:30 a.m. RN-B confirmed R4's record lacked an assisted living contract which is where the licensee listed the above listed required content. R9 R9's diagnoses included type two diabetes, Parkinson's disease (a progressive disorder that affects the nervous system and parts of the body controlled by the nerves), depression, anxiety, and heart failure. R9's unsigned Service Plan dated January 17, 2023, indicated she received services to include medication administration, blood glucose checks, assistance with transfers, showers, dressing, and toileting, and visual safety checks. On January 30, 2023, at 9:20 a.m. ULP-T was observed to provide a blood glucose check to R9 while in her apartment. R9's record lacked an assisted living with dementia care contract that contained the following required elements of the service plan: -the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff	{01650}		

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{01650}	Continued From page 109 providing services; and - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility; - 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 - 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 February 2, 2023, at 10:40 a.m. RN-B confirmed R4's record lacked an assisted living contract which is where the licensee listed the above required content. The licensee's 6.05 Service Plan policy dated August 1, 2021, indicated the resident service plans would include the required content according to 144G.70 Subd. 4. No further information was provided.	{01650}		
{01710} SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually.	{01710}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01710}	Continued From page 110	{01710}		

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review the licensee failed to ensure reassessment of medication management services at a minimum annually included all required content for six of six residents (R1, R2, R8, R3, R4, R9).

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 diagnoses included mild cognitive impairment (memory loss), Type 2 diabetes mellitus and hypertension (high blood pressure).

R1's service plan/care plan dated November 4, 2022, indicated R1 received medications administration.

On January 31, 2023, at 8:34 a.m. unlicensed personnel (ULP)-J was observed to administer medications to R1.

R1's Medication Administration Record (MAR) dated January 2023, indicated staff were administering one used for heart condition, three supplements, one for allergies, one used for depression, two used to treat high cholesterol,

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{01710}	Continued From page 111	{01710}		

two used to treat diabetes, one used to treat high blood pressure, one used for leg pain, two used for constipation, one used to treat anemia (a condition in which the blood does not make enough healthy red blood cells), one used to prevent blood clots, two used to remove ear wax, one used for acid reflux, four used for pain and one used for cough.

R1's Medication/Treatment/Therapy Assessment and Plan dated November 2, 2022, lacked identification and review of side effects and review of contraindications, allergic or adverse reactions, and actions to address these issues.

R2
R2's diagnoses included Alzheimer's disease.

R2's service plan/care plan dated January 19, 2023, indicated R2 received services including administration of medications.

R2's MAR dated January 2023, indicated staff were administering two medications for Alzheimer's disease, one used for heart condition, one used for depression, one antipsychotic, one used for bone density (the amount of bone mineral in bone tissue) and one used for pain.

R2's Medication/Treatment/Therapy Assessment and Plan dated January 8, 2023, lacked identification of side effects.

R8
R8's diagnoses included fluid overload, chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing) and hypertension.

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{01710}	Continued From page 112 R8's service plan/care plan dated August 31, 2020, indicated R8 received medication administration. R8's MAR dated January 2023, indicated staff were administering three vitamin supplements, one diuretic, one medication to treat high blood pressure, one medication for depression, one medication for allergies, two medications for pain, four medications to help breathing, one used to reduce inflammation, one used for constipation and one used to treat chest pain. R8's Medication/Treatment/Therapy Assessment and Plan dated November 26, 2022, lacked identification of side effects. On February 2, 2023, at 9:05 a.m. community director (CD)-V and registered nurse (RN)-D reviewed R1, R2 and R8's medication assessments. RN-D stated side effects for each medication were listed on the resident's MAR and could be viewed on the point click care system (computer program). RN-D tried to view the side effects through her computer and the ULP electronic tablets utilized, but was unable to show surveyors the side effects were inputted for each medication the residents were being administered. R3 R3's diagnoses included heart failure, atrial flutter on coumadin (blood thinner to prevent blood clots), peripheral vascular disease (a condition where there is poor blood circulation to extremities), chronic kidney disease, and polyosteoarthritis (multiple locations of arthritis). R3's service plan/care plan indicated last service plan review completed January 13, 2023,	{01710}		

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{01710}	Continued From page 113 indicated R3 received medication administration. R3's MAR dated January 2023, indicated R3 received medications that included one medication for heart failure, one for sleep, one vitamin supplement, one blood thinner, one for bowel, three ointments/creams for skin, two for constipation, two eye medications and one for mild pain. R3's Medication/Treatment/Therapy Assessment and Plan dated January 12, 2023, lacked identification of side effects. R4 R4's diagnoses include unspecified dementia, psychotic disturbance (history of hallucinations), mood disturbance and anxiety, depression, age related osteoporosis (brittle/weak bones susceptible to fractures) with history of second lumbar vertebra compression fracture, asthma, dry eyes, hypertension (high blood pressure) and hypothyroidism (a condition with poor thyroid gland function). R4's service plan/care plan dated November 1, 2022, indicated R4 received medication management. R4's MAR dated January 2023, included one for depression, one for hallucinations/agitation, one for anxiety, one for sleep, one for hypothyroidism (a condition with poor thyroid gland function), two for asthma, one for itching skin, four for pain, and one nutritional supplement drink, one for constipation, one cream for dry skin, one for excessive secretions, and one for nausea. R4's Medication/Treatment/Therapy Assessment and Plan dated December 12, 2022, lacked	{01710}		

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{01710}	Continued From page 114 identification of side effects. R9 R9's diagnoses included type two diabetes, Parkinson's disease (a progressive disorder that affects the nervous system and parts of the body controlled by the nerves), depression, anxiety, and heart failure. R9's unsigned Service Plan dated January 17, 2023, indicated she received medication administration. R9's MAR dated January 2023, included the following medications:one for bone density, one for cholesterol, one for heart failure, four for anxiety/depression, one for Parkinson's disease, one for allergies, two for type 2 diabetes, one for glaucoma (a degenerative eye disease), three for eye irritation, one for sleep, two for acid reflux/indigestion, one for edema (swelling), one for blood thinning, three supplements, one for hypotension (low blood pressure), three for constipation, one for bladder incontinence, three for pain, one for irritated scalp, one for low blood glucose, one for bowel health, one for nausea, one for nasal congestion. Additionally, R9's MAR indicated the following medications could be self administered on an as needed basis when R9 desired: -Citracal Plus-give 1 (one) tablet by mouth two times a day. Resident may self-administer; -Carboxymethylcellulose sodium solution 0.25%. Instill 1 drop in both eyes as needed for dry eyes, unsupervised self-administration; -Co-Enzyme Q10, give one capsule by mouth every 24 hours as needed. Resident may self-administer and take from own supply; -Glucose tablet, 1 gm (gram) give 4 (four) tablets	{01710}		

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{01710}	Continued From page 115	{01710}		

by mouth as needed for blood glucose less than 70 or symptomatic related to type 2 diabetes. OK for patient to self administer and have available in her room. May also give 6 (six) ounces juice, milk or regular pop if symptomatic, conscious and able to swallow;
-lactobacillus give 1 capsule by mouth every 24 hours as needed. Ok for resident to self-administer from own supply; and
-Tums Tablet Chewable 500 mg (milligrams). Give 2 (two) table by mouth every 24 hours as needed for indigestion or heartburn. Unsupervised self-administration

R9's Medication/Treatment/Therapy Assessment and Plan dated January 17, 2023, which indicated the licensee administered R9's medications. The assessment and plan lacked identification of side effects. Additionally, the licensee failed to complete an assessment of R9's ability to self-administer the medications as indicated above.

On February 2, 2023, at 9:05 a.m. CD-V and RN-D reviewed R3, R4 and R9's medication assessments. RN-D stated side effects for each medication were listed on the resident's MAR and could be viewed on the point click care system (computer program). RN-D tried to view the side effects through her computer and the ULP electronic tablets utilized, but was unable to show surveyors the side effects were inputted for each medication the residents were being administered. Regarding R9's medication assessment and plan, and whether the licensee assessed R9's ability to self administer some of her medications, RN-D stated, "I will need to see if anything was completed. Right now I am only seeing management view."

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{01710}	Continued From page 116 The licensee's Medication Management Assessment, Monitoring and Reassessment policy dated August 1, 2021, indicated "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". No further information was provided.	{01710}		
{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	{01730}		

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{01730}	Continued From page 117	{01730}		

nurse or appropriate licensed health professional when a problem arises with medication management services; and
(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.
(b) The medication management record must be current and updated when there are any changes.
(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan included all required content for five of six residents (R1, R2, R8, R4, R9).

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 diagnoses included mild cognitive

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{01730}	Continued From page 118	{01730}		

impairment, Type 2 diabetes mellitus, and hypertension (high blood pressure).

R1's service plan/care plan dated November 4, 2022, indicated R1 received services including administration of medications and vulnerability of "anxiety/depression/mental illness vulnerability interventions are: resident has a diagnosis of depression. Staff to administer medication as prescribed and update nurse of changes in mood of cognition."

On January 31, 2023, at 8:34 a.m. unlicensed personnel (ULP)-J was observed to administer medications to R1.

R1's Medication Administration Record (MAR) dated January 2023, indicated staff were administering one used for heart condition, three vitamin supplements, one used for allergies, one used for depression, two used to treat high cholesterol, two used to treat diabetes, one used to treat high blood pressure, one used for leg pain, two used for constipation, one used to treat anemia (a condition in which the blood does not make enough healthy red blood cells), one used to prevent blood clots, two used to remove ear wax, one used for acid reflux, four used for pain and one used for cough and one used for allergies.

R1's Medication/Treatment/Therapy Assessment and Plan was dated November 2, 2022.

R1's record lacked specific instructions for parameters for which as needed (PRN) medication to use first for ear wax removal (carbamide peroxide or mineral oil); lacked parameters for which PRN medication to use first for pain (oxycodone or lidocaine patch); lacked

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clear direction of parameters for blood pressure (BP) (did not identify systolic (top number) or diastolic (bottom number)/two numbers used to measure blood pressure) related to direction of "inform nurse if BP is 100<[greater] >[less]70"; and lacked identified specific behaviors/symptoms and monitoring of the behavioral symptoms to determine effectiveness of the medication for the use of citalopram (used to treat depression)medication.

R2
R2's diagnoses included Alzheimer's disease.

R2's service plan/care plan dated January 19, 2023, indicated R2 received medication administration and vulnerability of "anxiety/depression/mental illness vulnerability interventions are: resident has diagnoses of Alzheimer's dementia and depressive disorder. Has periods of increased confusion and anxiety. Medications are administered per prescriber's orders and monitored for efficacy. Staff provide visits when change in baseline is noted."

R2's MAR dated January 2023, indicated staff were administering two medications for Alzheimer's disease, one used for heart condition, one used for depression, one antipsychotic, one used for bone density (the amount of bone mineral in bone tissue) and one used for pain.

R2's Medication/Treatment/Therapy Assessment and Plan was dated January 8, 2023.

R2's record lacked identified specific behaviors/symptoms and monitoring of the behavioral symptoms to determine effectiveness of the medication for the use of escitalopram

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{01730}	Continued From page 120 (used to treat depression/anxiety) and risperidone (an antipsychotic medication used to treat schizophrenia/bipolar disorder) medications. R8 R8's diagnoses included fluid overload, chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing) and hypertension. R8's service plan/care plan dated August 31, 2020, indicated R8 received services including administration of medications and "anxiety/depression/mental illness vulnerability interventions are: medication administered as prescribed by PCP, will update PCP with any mood changes." R8's MAR dated January 2023, indicated staff were administering three vitamin supplements, one medication to reduce fluid in the body, one medication to treat high blood pressure, one medication for depression, one medication for allergies, two medications for pain, four medications to help breathing, one used to reduce inflammation, one used for constipation and one used to treat chest pain. R8's Medication/Treatment/Therapy Assessment and Plan was dated November 26, 2022. R8's record lacked specific instructions for parameters for which as needed (PRN) medication to use first for breathing (albuterol sulfate inhaler, albuterol sulfate nebulization solution, Ipratropium-Albuterol solution, prednisone); lacked parameters for hours apart for voltaren four times a day PRN (used for pain); lacked when to notify the nurse for use of PRN nitroglycerin (used to treat chest pain); and	{01730}		

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{01730}	Continued From page 121 lacked identified specific behaviors/symptoms and monitoring of the behavioral symptoms to determine effectiveness of the medication for the use of sertraline (used to treat depression) medication. On February 2, 2023, at 9:05 a.m. community director (CD)-V and registered nurse (RN)-D reviewed R1, R2 and R8's medication plan/records and verified R1, R2 and R8's record lacked the above. Regional nurse specialist (RNS)-E stated, "We are working on it." R4 R4's diagnoses include unspecified dementia, psychotic disturbance (history of hallucinations), mood disturbance and anxiety, depression, age related osteoporosis (brittle/weak bones susceptible to fractures) with history of second lumbar vertebra compression fracture, asthma, dry eyes, hypertension (high blood pressure) and hypothyroidism (a condition with poor thyroid gland function). R4's service plan/care plan dated November 1, 2022, indicated R4 received medication management. R4's MAR dated January 2023, included one for depression, one for hallucinations/agitation, one for anxiety, one for sleep, one for hypothyroidism (a condition with poor thyroid gland function), two for asthma, one for itching skin, four for pain, and one nutritional supplement drink, one for constipation, one cream for dry skin, one for excessive secretions, and one for nausea. R4's Medication/Treatment/Therapy Assessment and Plan was dated December 12, 2022.	{01730}		

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R4's record lacked clear directions to the ULP for which as needed pain medication (acetaminophen or morphine sulfate) should be used when R4 indicated pain, or symptoms of pain for which the ULP would need to contact a nurse. In addition, there were no instructions for the ULP to contact nursing for use of the as needed lorazepam or quetiapine.

R9
R9's diagnoses included type two diabetes, Parkinson's disease (a progressive disorder that affects the nervous system and parts of the body controlled by the nerves), depression, anxiety, and heart failure.

R9's unsigned Service Plan dated January 17, 2023, indicated she received medication administration.

R9's MAR dated January 2023, indicated she received medications including one for bone density, one for cholesterol, one for heart failure, four for anxiety/depression, one for Parkinson's disease, one for allergies, two for type 2 diabetes, one for glaucoma (a degenerative eye disease), three for eye irritation, one for sleep, two for acid reflux/indigestion, one for edema (swelling), one for blood thinning, three supplements, one for hypotension (low blood pressure), three for constipation, one for bladder incontinence, three for pain, one for irritated scalp, one for low blood glucose, one for bowel health, one for nausea, one for nasal congestion.

R9's Medication/Treatment/Therapy Assessment and Plan was dated January 17, 2023.

With R9's recent history of frequent falls and falls

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{01730}	Continued From page 123	{01730}		

with injuries, R9's record lacked direction/instruction for monitoring for bleeding and bruising with R9's use of apixaban (a blood thinner). Additionally, R9's record lacked the description of R9's symptoms of anxiety for staff to effectively recognize the need for an as needed administration of xanax (an antianxiety medication).

On February 2, 2023, at 11:00 a.m. CD-V and RN-D reviewed R4 and R9's medication plan/records and verified R4 and R9's record lacked the above and stated they would continue to make progress in getting the records to include the required content.

The licensee's Medication Management Individualized Plan policy dated August 1, 2021, indicated the licensee would develop and maintain a current individualized medication record for each resident based on the resident's assessment and would contain the content according to statue/rule.

The license's ALDC (assisted living dementia care) Behavioral Symptoms, Interventions and Nonpharmacological Approaches policy dated August 1, 2021, indicated the licensee supports person-centered and evidence based evaluation of behavioral symptoms and design of supports for intervention plans; including nonpharmacological interventions or practices in the following ways: would identify behavioral symptoms that negatively impact other residents and others in an assisted living facility and evaluate to determine potential interventions to minimize such behaviors. Interventions would be identified on the care plan or service plan.

No further information was provided.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

(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
01740 SS=D	144G.71 Subd. 6 Administration of medication Medications may be administered by a nurse, physician, or other licensed health practitioner authorized to administer medications or by unlicensed personnel who have been delegated medication administration tasks by a registered nurse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medication was administered as ordered for one of five residents (R8). 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: R8's physician Progress Note dated January 24, 2023, included an order for calcium carbonate 1,250 milligrams (mg) chewable tablet - chew two tablets (1,000 mg calcium total) daily with breakfast. R8's Medication Administration Record dated January 2023, included oyster shell calcium tablet 500 mg - give two tablets one time a day for supplement; however, R8's physician Progress Note dated January 24, 2023, did not include an order for the oyster shell medication.	01740		

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01740	Continued From page 125 R8 lacked administration of calcium carbonate 1,250 mg chewable tablet - chew two tablets (1,000 mg calcium total) daily with breakfast as prescribed. On February 2, 2023, at 12:45 p.m. registered nurse stated oyster shell medication for R8 was in the licensee medication cart that was what staff were administering to R8 instead of calcium carbonate chewable tablets. RN-D verified R8's prescriber orders as above. RN-D stated she would have to call the pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01740		
{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication	{01750}		

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{01750}	Continued From page 126	{01750}		

was administered as ordered for one of five 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:

R1's diagnoses included mild cognitive impairment, Type 2 diabetes mellitus and hypertension (high blood pressure).

R1's service plan/care plan dated November 4, 2022, indicated R1 received medication administration.

On January 31, 2023, at 8:34 a.m. unlicensed personnel (ULP)-J was observed to administer medications to R1. ULP-J was observed to administer insulin to R1 by insulin Pen injection. ULP-J placed a needle onto the Pen after removing the cap. ULP-J did not cleanse the rubber stopper with an alcohol pad prior to attaching the needle. ULP-J after injecting the medication into R1's abdomen area held the Pen in place for 4 seconds. ULP-J did not hold the Pen in place in R1's abdomen for 10 seconds after injection of the medication. ULP-J was observed to place a glass with Miralax (used for constipation) medication mixed in water next to R1 who was seated in a chair. ULP-J administered oral medications to R1, checked R1's blood pressure by utilizing an automatic

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{01750}	Continued From page 127	{01750}		

blood pressure cuff, checked R1's blood sugar, applied TED [thromboembolic deterrent] (used to reduce edema) stockings to R1's lower legs/feet and walked out of R1's apartment. The glass of Miralax remained undrank by R1. ULP-J did not ensure R1 drank the Miralax medication before leaving R1's apartment. At the time ULP-J stated she "always left the Miralax in [R1's] apartment" for R1 to drink on her own. ULP-J verified she did not cleanse the rubber pad on the insulin Pen prior to attaching the needle. ULP-J stated regarding holding the insulin Pen in R1's abdomen for only four seconds and not 10 seconds, "I was never taught that actually. Was just told to hold for a few seconds."

R1's record lacked a medication self-administration assessment for the ability to safely administer Miralax medication.

On February 1, 2023, at 12:28 pm. registered nurse (RN)-D stated R1's record did not have a "doctor order for self-administration" of the Miralax. RN-D stated for medications a resident would self-administer, the licensee obtains a doctor order. RN-D reviewed R1's record and stated R1's assessment does not address self-administration of Miralax. RN-D stated staff were to administer the Miralax to R1. RN-D stated the ULP should have cleansed the the insulin Pen with an alcohol pad prior to attaching the needle and should have held the needle in R1's abdomen and "counted to 10" after injecting the medication.

The licensee's Delegation of Assisted Living Services policy dated August 1, 2021, indicated the RN would ensure prior to delegation the ULP would be trained in the proper methods to perform the task or procedures for each resident

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{01750}	Continued From page 128 and was able to demonstrate the ability to completely follow the procedures and perform the tasks. No further information was provided.	{01750}		
{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: Based on observation, interview, and record review, the licensee failed to monitor the temperature of one of one medication storage refrigerators to ensure required medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On January 30, 2023, at 9:32 a.m. the medication refrigerator was observed with licensed practical nurse (LPN)-W. The refrigerator had one thermometer. The temperature reading on the thermometer was 38 degrees Fahrenheit (F).	{01880}		

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{01880}	Continued From page 129 The medication refrigerator contained the following medications: -Humulin N insulin pens (manufacturer instructions: before opening, store in refrigerator 36-46 degrees F) -Lantus insulin Pens (manufacturer instructions: before opening, store in refrigerator 36-46 degrees F) -Tubersol vials (box identified: store in refrigerator 35-46 degrees F) -Repatha (box identified: store in refrigerator 36-46 degrees F) -Tralicity injectable medication (box identified: store in refrigerator 36-46 degrees F) At the time of the observation LPN-W read the storage directions from the boxes of the medications as noted above. LPN-W showed the surveyor a sheet of paper titled Med Fridge Temperature Log dated January 2023. The log had temperatures recorded for six days for the dates of January 18, 19, 24, 25, 26, 27 and the temperatures recorded were 42, 36, 32, 34, and 34. LPN-W stated she was the only person recording temperatures for the medication refrigerator. LPN-W verified at the time the some of temperatures recorded for January 2023 fell below 36 degrees F and the temperature of the refrigerator was not being monitored daily. LPN-W stated, "They'll (medications) have to be replaced." On January 30, 2023, at 9:52 a.m. LPN-W stated "I really think this is my fault. When I read the thermometer, I was reading it wrong. I put a new thermometer in the refrigerator in January". LPN-W showed the surveyor the thermometer and stated the temperature she saw on the thermometer was 35 degrees when checking the thermometer. LPN-W provided December 2022,	{01880}		

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{01880}	Continued From page 130 temperature log for the medication refrigerator and stated the temperature was "not being done daily". LPN-W stated, "I am going to have the RA [resident assistant] do it now instead of me". The Medication Storage Logs sheet dated December 2022, included temperatures documented by LPN-W for the following: -25th; 44 degrees F -26th; 43 degrees F -29th; 44 degrees F -30th; 43 degrees F The licensee's Medication Storage policy (7.08) dated August 1, 2021, read "When medications are managed and stored by [licensee], medications will be kept securely locked and stored per manufacturer's directions. Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen)." No further information was provided.	{01880}		
{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;	{01940}		

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{01940}	Continued From page 131 (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 the treatment plan included all required content for five of five residents (R1, R8, R3, R4, R9). 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	{01940}		

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{01940}	Continued From page 132 R1's diagnoses included mild cognitive impairment, Type 2 diabetes mellitus and hypertension (high blood pressure). R1's service plan/care plan dated November 4, 2022, indicated R1 received services including blood sugar checks and TED (thrombus embolic deterrent) hose/compression stockings (used to reduce swelling) applied as ordered. On January 31, 2023, at 8:34 a.m. unlicensed personnel (ULP)-J was observed to administer medications to R1, check R1's blood pressure, check R1's blood sugar and applied knee high TED stockings to R1's lower legs/feet. R1's documentation of services sheets dated January 2023, included "compression stockings" with times of signatures for 9 a.m. and 8 p.m. by staff. R1's Medication/Treatment/Therapy Assessment and Plan was dated November 2, 2022. The plan further indicated "the above items may be delegated to trained unlicensed employees". R1's plan/record lacked the following: -documentation of specific resident instructions relating to the treatments or therapy administration (TEDs knee high or thigh high) -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services (TEDs); -identification of treatment or therapy tasks that "will be delegated to unlicensed personnel" (TEDs, Blood sugar check). R8 R8's diagnoses included fluid overload, chronic obstructive pulmonary disease (a condition	{01940}		

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{01940}	Continued From page 133 involving constriction of the airways and difficulty or discomfort in breathing) and hypertension. R8's service plan/care plan dated August 31, 2020, indicated R8 received services including treatments: CPAP (a machine used for breathing)/TED stockings. On January 31, 2023, at 6:35 a.m. ULP-U stated R8 was already awake and dressed. ULP-U stated she set up R8's toothbrush and he brushed his teeth, assisted R8 to shave, wash face, change incontinent product, dress and put on R8's TED stockings. R1's documentation of services sheets dated January 2023, included "compression stockings" every shift, with staff signature times in the a.m. and bedtime. R8 record lacked documentation for providing the treatment services of CPAP. R8's physician Progress Notes dated January 24, 2023, included pressure ulcer of right hip stage 2. On exam pressure ulcer measuring 5 cm (centimeters) x 6.5 cm over the right trochanteric area. Vesicles had been present that are now broken open. Granulating tissue in wound bed. Area is slightly erythemic (reddening of the skin), no purulent drainage (a sign of infection), no odor. provided written orders for the facility to wash the wound with soap and water before changing the dressing. To change the dressing every Monday, Wednesday, and Friday. To inspect the wound for infection and report concerns. To help the patient reposition and off load pressure by avoiding sleeping on his right side at night.	{01940}		

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{01940}	Continued From page 134 R8's Progress Notes included the following: -January 24, 2022, documented by licensed practical nurse (LPN)-W, resident assistant (RA) "was doing morning cares with resident and noted a sore on right hip. RA notified CNP [certified nurse practitioner] who was in the room to see the resident. Resident stated his right hip was hurt for about two to three weeks. CNP notified this writer and we noted stage 2 pressure sore 1" X 2" over the right trochanteric area. Vesicles had been present that are now broken open. Granulation tissue in wound bed. Area is slightly erythemic, no purulent drainage and no odor notes. Area covered with foam dressing. Dressing will be changed every three days by nurse with Mepilex border dressing." R8's Medication/Treatment/Therapy Assessment and Plan was dated November 26, 2022. The plan further indicated "the above items may be delegated to trained unlicensed employees". R8's plan/record lacked the following: -a statement of the type of services that will be provided (pressure wound dressing changes by the licensed nurse of the licensee); -documentation of specific resident instructions relating to the treatments or therapy administration (CPAP/TEDs knee high or thigh high); -identification of treatment or therapy tasks that "will be delegated to unlicensed personnel" (CPAP/TEDs); -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services (CPAP/TEDs); and -any resident-specific requirements relating to documentation of treatment and therapy received (CPAP/TEDs).	{01940}		

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{01940}	Continued From page 135 On February 2, 2023, at 9:05 a.m. community director (CD)-V and registered nurse (RN)-D reviewed R1 and R8's records and verified R1 and R8's records lacked the above. CD-V stated ULP were not providing service of wound dressing changes, only the nurses of the licensee were allowed to provide wound dressing changes. CD-V, RN-D and regional nurse specialist (RNS)-E verified the licensee's Medication/Treatment/Therapy Assessment and Plan utilized for residents of the facility receiving treatments read "the above items may be delegated to trained unlicensed employees" and did not indicate on the plan "identification of treatment or therapy tasks that will be delegated to unlicensed personnel" as required. R3 R3's diagnoses included heart failure, atrial flutter on coumadin (blood thinner to prevent blood clots), peripheral vascular disease (a condition where there is poor blood circulation to extremities), chronic kidney disease, benign prostatic hyperplasia with urinary retention and lower urinary tract symptoms (enlarged prostate causing poor bladder emptying), presence of suprapubic urinary stoma/catheter (opening to the bladder through the abdomen for urinary catheter placement), polyosteoarthritis (multiple locations of arthritis). R3's service plan/care plan indicated last service plan review completed January 13, 2023, indicated R3 received services that included bathing assistance, daily lower extremity compression wrap assistance, suprapubic catheter site care and catheter bag management, skin checks, medication administration, dressing cues with some hands-on assistance, visual checks every shift, housekeeping, and laundry.	{01940}		

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{01940}	Continued From page 136	{01940}		

Resident receives wound care and INR (international normalized ratio/lab calculation based on prothrombin test results; a test measuring how long it takes a blood clot to form in a blood sample) by an outside agency.

On January 31, 2023, at 7:00 a.m. ULP-Q was observed to provide oral medications, topical cream to feet, compression wraps to both lower extremities, suprapubic catheter site care, urinary bag maintenance and exchange, light sponge bath, and dressing assistance. Two dressings were observed on R3's right foot. ULP-Q stated the wound care was completed by a home health agency. The ULP do not do anything with the dressings.

R3's Medication Treatment Therapy assessment and plan was dated January 12, 2023.

The documentation of service sheets dated January 2023, included the following treatment related tasks:
- "Compression wraps: Both Legs. 1. Put on high sock to protect skin. 2. Apply 2 stretch wraps, first wrap: from the base of the toes to just above the ankles. 2nd Apply wider wrap from above the ankle to just below the knees. Both in spiral pattern. Put on size H Tubi grips over compression wraps to help keep them in place. Compression wraps to be removed when resident prepares for bed" indicated for ULP times of 7:30 a.m. and 10:30 p.m.;
- "Q [each] shift: hydrocolloid dressing to L [left] foot."; and
-"Suprapubic Catheter Care" indicated times of 7:30 a.m. and 10:15 p.m.

R3's Medication/Treatment/Therapy Assessment and Plan was dated January 12, 2023. The plan

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

(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 137	{01940}		

further indicated "the above items may be delegated to trained unlicensed employees". R3's plan/record lacked the following:
-directions with what to report to nursing regarding redness, warmth, open skin with R3's compression wraps;
-instruction of what ULP to do if R3's hydrocolloid dressings were missing or not intact from R3's Left foot/toes; and
-identification of treatment or therapy tasks that "will be delegated to unlicensed personnel" (catheter care, compression wraps, hydrocolloid dressing monitoring).

On February 2, 2023, at 9:15 a.m. RN-D and CD-V stated the medication and treatment plan will be edited to reflect the required language of what treatments "will be delegated".

On February, 2, 2023, at 9:30 a.m. RN-D and CD-V stated "the role of the ULP regarding R3's hydrocolloid dressings was to ensure the dressings remained intact. The licensee does not manage anything with the dressing other than ensuring they are in place and will notify the home health agency for concerns." RN-D stated the ULP should know to call the nurse when the dressings are not intact or secured. RN-D confirmed there was not additional information in a "drop down box" to ensure staff would know what to look for with R3's treatments and "much of this information is taught in a delegations class."

R4
R4's diagnoses include unspecified dementia, psychotic disturbance (history of hallucinations), mood disturbance and anxiety, depression, age related osteoporosis (brittle/weak bones

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{01940}	Continued From page 138	{01940}		

susceptible to fractures) with history of second lumbar vertebra compression fracture, asthma, dry eyes, hypertension (high blood pressure) and hypothyroidism (a condition with poor thyroid gland function).

R4's service plan/care plan dated November 1, 2022, indicated R4 received services to include medication management, weekly bathing/showering/sponge bath assistance, grooming/oral hygiene, assistance with glasses and hearing aids, dressing assistance/cues, assistance each morning and evening with TED stockings (compression stockings), ace wrap to lower right extremity as needed, eating encouragement, cues to use walker, safety checks (eight times per shift), toileting assistance, escort to and from dining area and activities, housekeeping, laundry and housekeeping. Additionally, R4 began receiving hospice services on August 30, 2022.

On January 31, 2023, at 2:00 p.m. ULP-Q stated R4 was currently resting in bed, staff continue to provide all personal cares, and stated R4 no longer wore her TED stockings .

R4's documentation of service sheets dated January 2023, indicated Compression stockings: put on and off and wash out with the staff documentation time "Q [every] shift." Staff documentation indicated the tasks had been performed on all days in January except January 11 and 13, 2023.
Additionally, the documentation of service sheets indicated the task of "Dressing: Apply Ace wrap to lower right extremity. Figure 8 [eight] beginning at toes up to knees. Apply tubigrips beneath wraps, on in AM, off at PM."
The time indicated "PRN [as needed], and had

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{01940}	Continued From page 139 been documented as completed on January 26, 2023, at 10:59 p.m. R4's Medication/Treatment/Therapy Assessment and Plan was dated December 22, 2022. The plan further indicated "the above items may be delegated to trained unlicensed employees". R4's plan/record lacked the following: -directions with what to report to nursing regarding concerns with the use of TED stockings and Ace wraps (redness, warmth, open skin areas); and -identification of treatment or therapy tasks that "will be delegated to unlicensed personnel" (TED stockings, Ace wraps) On February 2, 2023, at 9:35 a.m. RN-D stated she had been provided a new order for R4's TED stockings for PRN use as R4 tolerated. RN-D confirmed R3's record lacked the instructions for when to contact nursing and the verbiage of what treatments or therapy tasks "will be delegated to ULP." R9 R9's diagnoses included type two diabetes, Parkinson's disease (a progressive disorder that affects the nervous system and parts of the body controlled by the nerves), depression, anxiety, and heart failure. R9's unsigned Service Plan dated January 17, 2023, indicated she received blood glucose checks. On January 30, 2023, at 9:20 a.m. ULP-T was observed to provide a blood glucose check to R9 while in her apartment. R9's MAR dated January 2023, indicated the	{01940}		

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{01940}	Continued From page 140 treatment of "Check blood glucose twice daily", with times for staff to complete as 8:00 a.m. and 4:45 p.m. R9's Medication/Treatment/Therapy Assessment and Plan was dated January 17, 2023. The plan further indicated "the above items may be delegated to trained unlicensed employees". The plan lacked identification of treatment or therapy tasks that "will be delegated to unlicensed personnel" (blood glucose checks). On February 2, 2023, at 10:45 a.m. RN-D stated the licensee will make edits to the treatment and therapy plan to the proper verbiage. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain the required content in reference to 144G.72 Subd. 3. No further information was provided.	{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	{01950}		

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{01950}	Continued From page 141 registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and 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) instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident and three of six unlicensed personnel (ULP-U, ULP-S, and ULP-T) had 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: ULP TRAINING AND DEMONSTRATED COMPETENCY ULP-U During the entrance conference on January 30, 2023, at 11:47 a.m. community director (CM)-V stated the licensee was utilizing staff from a	{01950}		

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supplemental staffing agency to maintain staffing at the facility.

On January 31, 2023, at 6:35 a.m. ULP-U stated she had not received any orientation or training and competency from any nurse of the licensee. ULP-U stated, "Just aides do orientation, no one else showed me anything, just aides". ULP-U stated, "other aides showed me around the facility". ULP-U stated she worked in the facility prior to today, "once in a while". ULP-U stated for treatments as ace wraps (compression wraps used to reduce swelling) she had "never applied ace wraps" and would "ask someone how to do".

On January 31, 2023, at 8:11 a.m. the surveyor asked CD-V for ULP-U's employee file the licensee had on file. CD-V stated, "[licensed practical nurse (LPN)-W] would have that".

ULP-U employee record contained catheter care, suprapubic catheter care and CPAP training indicating education and observation of competency was completed. The sheet was signed by LPN-W and ULP-U, with date of signatures for January 5, 2023.

On January 31, 2023, at 9:23 a.m. the surveyor showed ULP-U documented information in ULP-U's record. ULP-U stated, "the nurse [LPN-W] had me sign today and write the date of January 5, 2023" for the date of signature. ULP-U stated,"the aide went over some of the information" in the record prior to today. ULP-U stated, "The nurse went over it with me today".

On January 31, 2023, at 9:25 a.m. LPN-W stated she had ULP-U backdate information in ULP-U's record today for the date of January 5, 2023. LPN-W stated, "I did delegated task training and

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{01950}	Continued From page 143	{01950}		

competency with [ULP-U]". LPN-W stated ULP-U "had no training or competency with an RN".

ULP-U's record lacked documented evidence the licensee had trained and determined ULP-U was competent for delegated tasks of TEDs, Ace wraps, leg brace, changing catheter drainage bag to catheter leg bag and CPAP.

ULP-S
ULP-S's date of hire was August 22, 2017. ULP-S provided direct care and services to the licensee residents.

ULP-S's record included documented training and competency for the delegated task of ace wraps signed by a RN of the licensee on December 7, 2022, signed by LPN-W with no date and signed by ULP-S on January 20, 2023.

On January 31, 2023, at 12:22 p.m. LPN-W stated regarding why the RN date of signature was December 7, 2023, and ULP-S's signature was January 20, 2023, "I think she [the RN] makes copies and doesn't change the date, but I can't say for sure. I wasn't here for training."

On February 1, 2023, at 12:28 p.m. community director (CD)-V stated regarding LPN-W having ULP-U back date documents, "we don't do that, not our practice". CD-V stated, "when training done, document on the day done". RN-D verified training and competency for delegated tasks was to be completed by an RN.

On February 2, 2023, at 9:05 a.m. CD-V stated regarding ULP-S's training and competency for treatments (as ace wrap above), the licensee had completed an investigation regarding the different dates for signature by the RN and ULP-S. The

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{01950}	Continued From page 144 investigation information provided to surveyor indicated LPN-W "had an RA [resident assistant] sign a task delegation packet with an RN's signature on it that she had photocopied"; therefore ULP-S lacked documented training and competency for ace wraps. R3 R3's service plan/care plan indicated last service plan review completed January 13, 2023, indicated R3 received services that included daily lower extremity compression wrap assistance. On January 31, 2023, at 7:00 a.m. ULP-Q was observed to provide oral medications, topical cream to feet, and wraps to both lower extremities. R3's documentation of service sheets dated January 2023, included "Compression wraps: Both Legs. 1. Put on high sock to protect skin. 2. Apply 2 stretch wraps, first wrap: from the base of the toes to just above the ankles. 2nd Apply wider wrap from above the ankle to just below the knees. Both in spiral pattern. Put on size H Tubi grips over compression wraps to help keep them in place. Compression wraps to be removed when resident prepares for bed." indicated for ULP times of 7:30 a.m. and 10:30 p.m. R3's provider order dated December 16, 2022, indicated instructions for the compression stockings to read, "Compression: both legs; wear compression wraps anytime you are out of bed; Compression needs to be applied first thing in the morning; Always wear some form of barrier between your skin and the compression wrap (knee-high socks for example); If wraps loosen or fall down, you need to enwrap our compression; Putting on your wraps: Put on a knee-high sock to protect your skin; next you apply two low stretch	{01950}		

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{01950}	Continued From page 145	{01950}		

wraps to both legs; you apply the narrower wrap from the base of your toes to just above the ankle. The wider wrap does from just above the ankle to just below the knee; These wraps should be applied using a spiral pattern; Finally apply a layer of size H tubigrip over the wraps to help keep them in place."

R3's home health agency notes included the following entries:
-January 6, 2023, read "I have updated [R3] sister that he needs shoes. I hope he gets some. Also had his wraps under his socks this visit. I did let the one RA [resident assistant] that came in know that they go over the socks."
-January 9, 2023, read "No dressing present on his feet when I unwrapped them today. For the toe and plantar [inner part of foot just below great toe] this is of no concern as they are covered. However both blisters are not. Otherwise I continue to encourage him to make a follow up appointment and get shoes."
-January 11, 2023, read "Cath [catheter] changed. No concerns. We are making great progress on getting his legs wrapped right. All parts were there today. I did put up a short noted next to yours so the RAs know what order they go in. Today it was backwards. I hope this helps."
-January 13, 2023, read "Wraps were again on backwards. I did let the RA that came in know that the order is posted on the wall. I hope this helps. Wound has not changed. I have also told his sister about the Good Feet Store. I hope we an can some shoes soon."
-January 27, 2023, read "Noted wraps backwards today with white sock on top of wraps. No changes to wounds. I continue to encourage [R3] follow up appointment with wound care."

The licensee failed to ensure ULP were trained

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{01950}	Continued From page 146 and demonstrated competency for R3's specific compression wrap procedure. ULP-T ULP-T had a hire date of October 4, 2022, and provided direct care and services to the licensee's residents. ULP-T's record lacked evidence of training and demonstrated competency for R3's specific compression wrap procedure. On February 2, 2023, at 9:30 a.m. regional nurse specialist (RNS)-E stated RN-C (no longer with agency) and other RNs along with LPN-W have been working with the ULP to ensure they are trained on R3's compression wrap technique and stated there was not evidence of training or competencies completed and included in ULP record. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain the required content in reference to 144G.72 Subd. 3. The licensee Temporary and Contracted Staff policy dated August 1, 2021, indicated temporary supplemental staffing would only be used if they meet the same requirements required as hired employees and would be treated as if they were staff of the facility. Competency evaluation results must be obtained for unlicensed personnel who would be assigned to perform delegated nursing services. Staff must be orientated tot he individual needs of each assigned resident, the service plan, methods of documentation, and other	{01950}		

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{01950}	Continued From page 147 elements required to provide safe home care services. No further information was provided.	{01950}		
{01960} SS=D	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 interview and record review, the licensee failed to ensure the signature and title of the person who administered the treatment or therapy and the date and time of administration for provision of treatment administration for one of three residents (R8). 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).	{01960}		

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{01960}	Continued From page 148 The findings include: R8's service plan/care plan dated August 31, 2020, indicated R8 received services including treatments: CPAP (a machine used for breathing)/TED (thromboembolic deterrent) stockings. On January 31, 2023, at 6:35 a.m. unlicensed personnel (ULP)-U stated R8 was already awake and dressed. ULP-U stated she set up R8's toothbrush and he brushed his teeth, assisted R8 to shave, wash face, change incontinent product, dress and put on R8's TED stockings. R1's documentation of services sheets dated January 2023, included "compression stockings Q [every] shift" with staff signatures times in the a.m. and bedtime. The sheet did not include a specific time for staff to apply and remove TEDs for R8. R8's record further identified the following: -R8's physician Progress Notes dated January 24, 2023, included pressure ulcer of right hip stage 2. On exam pressure ulcer measuring 5 cm (centimeters) x 6.5 cm over the right trochanteric area. Vesicles had been present that are now broken open. Granulating tissue in wound bed. Area is slightly erythemic (reddening of the skin), no purulent drainage (a sign of infection), no odor. Provided written orders for the facility to wash the wound with soap and water before changing the dressing. To change the dressing every Monday, Wednesday, and Friday. To inspect the wound for infection and report concerns. To help the patient reposition and off load pressure by avoiding sleeping on his right side at night.	{01960}		

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{01960}	Continued From page 149 R8's record lacked documentation for providing the treatment service of CPAP and wound dressing changes. On February 2, 2023, at 9:05 a.m. community director (CD)-V and registered nurse (RN)-D reviewed R8's record and verified R8's record lacked the documentation as above. CD-V stated ULP were not providing service of wound dressing changes, only the nurses of the licensee were allowed to provide wound dressing changes. The licensee's Medication and Treatment Record Documentation and Refusal policy dated August 1, 2021, indicated documentation of treatment/therapy administration would be completed by the person who performed the task immediately after the assistance/administration was completed. No further information was provided.	{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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescriber's orders for treatment or therapy for two of five	{01970}		

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ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

(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
{01970}	Continued From page 150	{01970}		

residents (R8, R4).

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

The findings include:

R8
R8's service plan/care plan dated August 31, 2020, indicated R8 received services including treatments: CPAP (a machine used for breathing)/TED (thromboembolic deterrent) stockings.

On January 31, 2023, at 6:35 a.m. unlicensed personnel (ULP)-U stated R8 was already awake and dressed. ULP-U stated she set up R8's toothbrush and he brushed his teeth, assisted R8 to shave, wash face, change incontinent product, dress and put on R8's TED stockings.

R8's physician Progress Note dated July 5, 2022, indicated "he is non compliant with CPAP. Encouraged him to use his CPAP".

R8's prescription for knee high compression garment was dated December 23, 2021.

R8's record lacked prescriber orders for CPAP and knee high TEDs.

On February 2, 2023, at 9:05 a.m. registered nurse (RN)-D reviewed R8's record and verified

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{01970}	Continued From page 151 R8's record lacked prescriber orders for CPAP and knee high TEDs. R4 R4's service plan/care plan dated November 1, 2022, indicated R4 received services to include medication management, weekly bathing/showering/sponge bath assistance, grooming/oral hygiene, assistance with glasses and hearing aids, dressing assistance/cues, assistance each morning and evening with TED stockings, ace wrap to lower right extremity as needed, eating encouragement, cues to use walker, safety checks (eight times per shift), toileting assistance, escort to and from dining area and activities, housekeeping, laundry and housekeeping. Additionally, R4 began receiving hospice services on August 30, 2022. On January 31, 2023, at 2:00 p.m. ULP-Q stated R4 was currently resting in bed, staff continue to provide all personal cares, and stated R4 no longer wore her TED (thromboembolic deterrent) stockings. R4's Task documentation record dated January 2023, indicated "Compression Stockings, put on and off and wash out, Q [each] shift." The record included ULP initials twice daily for most days/evenings in January 2023. On January 31, 2023, at 12:30 p.m. RN-D provided the surveyor with an order dated January 6, 2021, which read "DC [discontinue] previous order for ace wraps, May use ace wraps for compression as needed, if stockings are not available. Please wrap from toe to knee in figure 8 (eight) fashion, provide soft padding beneath ace wraps for skin protection" and stated "this is	{01970}		

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{01970}	Continued From page 152 all we have." On February 2, 2023 at 9:45 a.m. RN-D provided the surveyor with a new order from R4's nurse practitioner which read, "apply compression stockings daily, as patient tolerates, remove in the evening. No further information was provided.	{01970}		
{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 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	{02170}		

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{02170}	Continued From page 153	{02170}		

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 conduct an individualized written activity evaluation that addressed all six provisions and failed to develop an individualized activity plan based on the evaluation for three of three residents (R2, R8, 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:

The licensee held an assisted living with dementia care license effective August 1, 2022.

R2
R2's diagnoses included Alzheimer's disease.

R2's service plan/care plan dated December 9,

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{02170}	Continued From page 154 2021, indicated R2 received services including activities, meals, assistance with transportation/appointments, pain, cardiac, bathing, grooming/oral hygiene, dressing/undressing, medication administration, weight monitoring, vitals, toileting, assistance with ambulation long distances, fall interventions, assistance with safety in emergency situations and skin condition. On January 31, 2023, at 7:54 a.m. unlicensed personnel (ULP)-U was observed to assist R2 with dressing and grooming (in the memory care unit). R2's record lacked an evaluation of 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, R2's record lacked the development of an individualized activity plan. R8 R8's diagnoses included fluid overload, chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing) and hypertension. R8's service plan/care plan dated August 31, 2020, indicated R8 received services including activities, pain, risk of choking monitoring, bathing, dressing/undressing, meals, medication administration, treatments: CPAP/TED (thromboembolic deterrent)	{02170}		

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{02170}	Continued From page 155 stockings/weights/vitals, toileting assist, lotion feet after shower, wheelchair assistance long distances, Mobility assistance, visual checks for safety, assistance with emergency situations, fall interventions, daily bed making/room tidy, housekeeping, laundry, trash removal and linen changes. On January 31, 2023, at 6:35 a.m. ULP-U stated R8 was already awake and dressed. ULP-U stated she set up R8's toothbrush and he brushed his teeth, assisted R8 to shave, wash face, change incontinent product, dress and put on R8's TED stockings. On January 31, 2023, at 7:52 a.m. R8 was observed eating breakfast in the dining room of the memory care unit. R8's record lacked an evaluation of 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, R8's record lacked the development of an individualized activity plan. R4 R4's diagnoses include unspecified dementia, psychotic disturbance (history of hallucinations), mood disturbance and anxiety. R4's Service Plan/careplan dated November 1, 2022, indicated R4 received services to include	{02170}		

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{02170}	Continued From page 156	{02170}		

medication management, weekly bathing/showering/sponge bath assistance, grooming/oral hygiene, assistance with glasses and hearing aids, dressing assistance/cues, assistance each morning and evening with TED stockings, ace wrap to lower right extremity as needed, eating encouragement, cues to use walker, safety checks (eight times per shift), toileting assistance, escort to and from dining area and activities, housekeeping, laundry and housekeeping. Additionally, R4 began receiving hospice services on August 30, 2022.

R4's s record lacked an evaluation of 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.

Additionally, R4's record lacked the development of an individualized activity plan.

On February 2, 2023, at 9:05 a.m. registered nurse specialist (RNS)-E stated starting next month the licensee would be rolling out a new assessment six dimensions of wellness and an activity plan was also included.

On February 2, 2023 at 9:35 a.m. registered nurse (RN)-D stated no changes have been made. The licensee had sent a form "all about me" and placed a reminder phone call to R4's representative, with no responses.

The licensee's ALDC Life Enrichment Programs,

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{02170}	Continued From page 157 Activities and Outdoor Space policy (3.05) dated August 1, 2022, indicated as an assisted living with dementia care licensed facility, the corporations communities strive to provide valuable activities and life enrichment programs for residents with Alzheimer's disease and other dementia's. Each resident must be evaluated for activities according to the licensing rules of the facility. 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. No further information provided.	{02170}		
{02180} SS=E	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Existing housing with services establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted living facility license must provide residents with regular access to outdoor space. A licensee with new construction on or after August 1, 2021, or a new licensee that was not previously registered under chapter 144D prior to August 1, 2021, must provide regular access to secured outdoor space on the premises of the facility. A resident's access to outdoor space must be in accordance with the resident's documented care plan.	{02180}		

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{02180}	Continued From page 158 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure behavioral symptoms were identified and were addressed on the care plan for three of three residents (R2, R8, 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: The licensee held an assisted living with dementia care license, effective August 1, 2022. R2 R2's diagnoses included Alzheimer's disease. R2's service plan/care plan dated January 19, 2023, indicated R2 received services including administration of medications and vulnerability of "anxiety/depression/mental illness vulnerability interventions are: resident has diagnoses of Alzheimer's dementia and depressive disorder. Has periods of increased confusion and anxiety. Medications are administered per prescriber's orders and monitored for efficacy. Staff provide visits when change in baseline is noted." On January 31, 2023, at 7:54 a.m. unlicensed	{02180}		

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{02180}	Continued From page 159 personnel (ULP)-U was observed to assist R2 with dressing and grooming (in the memory care unit). R2's Medication Administration Record (MAR) dated January 2022, indicated staff were administering escitalopram (antidepressant used to treat depression and generalized anxiety disorder) 10 milligrams (mg) one time a day for major depressive disorder and risperidone (antipsychotic medication used to treat schizophrenia, bipolar disorder, or irritability associated with autistic disorder) 0.25 mg at bedtime for Alzheimer's disease. R2's service plan/care plan lacked specific behaviors/symptoms and non-pharmalogical interventions to implement for behavioral symptoms that negatively impact the resident and others. R8 R8's diagnoses included fluid overload, chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing) and hypertension (abnormally high blood pressure). R8's service plan/care plan dated August 31, 2020, indicated R8 received services including administration of medications and "anxiety/depression/mental illness vulnerability interventions are: medication administered as prescribed by PCP, will update PCP with any mood changes." R8's MAR dated January 2023, indicated staff were administering sertraline 50 mg daily for depression.	{02180}		

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{02180}	Continued From page 160 R8's service plan/care plan lacked specific behaviors/symptoms and non-pharmalogical interventions to implement for behavioral symptoms that negatively impact the resident and others. On February 2, 2023, at 9:05 a.m. community director (CD)-V and registered nurse (RN)-D reviewed R2 and R8's records and verified R2 and R8's records lacked the above. R4 R4's diagnoses include unspecified dementia, psychotic disturbance (history of hallucinations), mood disturbance, anxiety and depression. R4's service plan/care plan dated November 1, 2022, indicated R4 received services to include medication management and vulnerability of "anxiety/depression/mental illness vulnerability interventions are: 24/7 supervision in MC (memory care) unit; medications managed and administered by (licensee's) staff. Observe and report mood changes to the nurse." On January 31, 2023 at 2:00 p.m. ULP-Q stated R4 was currently resting in bed, staff continue to provide all personal cares in the memory care unit. R4's MAR dated January 2023, indicated staff were administering the following medications: -escitalopram oxalate 10 mg, one tablet by mouth daily for major depressive disorder -quetiapine fumearate 25 mg, give 0.5 tablet by mouth at bedtime and give 0.5 tablet every 24 hours as needed for delirium/hallucinations -lorazepam 0.5 mg, give 1 tablet by mouth every 4 hours as needed for anxiety R4's service plan/care plan lacked specific	{02180}		

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{02180}	Continued From page 161 behaviors/symptoms and non-pharmalogical interventions to implement for behavioral symptoms that negatively impact the resident and others. On February 2, 2023, at 9:45 a.m. RN-D and CD-V confirmed R4's record lacked the above content. The license's ALDC (assisted living dementia care) Behavioral Symptoms, Interventions and Nonpharmacological Approaches policy dated August 1, 2021, indicated the licensee supports person-centered and evidence based evaluation of behavioral symptoms and design of supports for intervention plans; including nonpharmacological interventions or practices in the following ways: would identify behavioral symptoms that negatively impact other residents and others in an assisted living facility and evaluate to determine potential interventions to minimize such behaviors. Interventions would be identified on the care plan or service plan. No further information was provided.	{02180}		
{03000} SS=E	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,	{03000}		

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{03000}	Continued From page 162 unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, 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:	{03000}		

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{03000}	Continued From page 163	{03000}		

Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) a suspected maltreatment for one of one resident (R2) and significant medication errors for two of two residents (R1, R3).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

The licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) a suspected maltreatment for R2 and significant medication errors for R1 and R3 as noted below from a previous survey exited on November 4, 2022.

R2
R2's service plan/care plan last reviewed April 15, 2022, included assistance with activities of daily living and administration of medications.

R2's incident report dated August 7, 2022, indicated resident assistant (RA) witnessed a resident with a cup that contained bleach. "Resident states she drank some of it." The registered nurse (RN) on call was notified. RN asked if the resident had any signs of ingesting the bleach. The resident did not appear to have any odor of bleach on her. Poison control was

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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
{03000}	Continued From page 164	{03000}		

called and stated that if the resident had ingested bleach, she would have burns on her mouth. The resident did not have any signs of ingesting bleach. A family member was notified and did not wish to have R1 sent into the emergency room (ER). RN instructed staff to continue to monitor R1 for nausea and vomiting throughout the night. The report further indicated the laundry room door had been left open. "RN reiterated to staff the importance of keeping the laundry room door closed and lacked to keep chemicals away from resident's."

The licensee failed to ensure immediate report of the incident to MAARC.

On November 3, 2022, at 1:33 p.m. RN-C and regional nurse specialist (RNS)-E stated the licensee's process for incidents was to fill out an incident report, notify the doctor, notify family, talk to staff and provide education. RN-C stated she had not filed a report to MAARC regarding the incident. RN-C stated R2 "did not drink bleach," as the poison control center informed if R2 had drank some of the bleach, R2 would of had "burns and blisters inside mouth." When asked if the incident had been reported to MAARC, RNS-E stated, "I don't recall this one." When asked when a MAARC report would be reported, RNS-E stated, "If negative outcome, make a MAARC report."

R1
R1's service plan/care plan dated October 20, 2022, included medication administration, insulin administration and blood sugar checks.

R1's Medication Error report dated June 14, 2022, documented by licensed practical nurse (LPN)-R, indicated she received a call from the

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	24053	A. BUILDING: _____ B. WING _____	R 02/02/2023

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{03000}	Continued From page 165	{03000}		

RA informing the resident's insulin was still on hold. Most of the other medications were taken off hold when the resident returned from the hospital. The resident's blood sugar was 345. The RN who received the resident back to the community was contacted. "She instructed to take Lantus 24 units off hold." A phone call was placed to the doctor on call to verify how many units of insulin was to be given. The doctor on call "after review of resident hospital stay and discharge papers informs that 10 units of Lantus was to be given." The doctor was informed R1 received 24 units of Lantus at 1945 (7:45 p.m.) The doctor gave a verbal order to recheck blood sugar at 2145 (9:45 p.m.) If above 120, no further action needed tonight. Recheck on blood sugar was 249.

R1's After Visit Summary dated June 1, 2022, through June 14, 2022, indicated Lantus 10 units under the skin at bedtime. Last time this was given: 10 units on June 13, 2022, 7:00 p.m.

The licensee failed to ensure immediate report of a significant medication error to MAARC.

On November 3, 2022, at 8:41 a.m. LPN-R stated, "Yes, [R1] returned from the hospital" on June 14, 2022. LPN-R stated R1's family member "sat orders on [RN-C's] desk " and RN-C stated "she would take care of them" and "asked me to fax two to three orders to the pharmacy. I got a call [from staff person] insulin was still on hold" (in the computer system) and I informed the staff person to call RN-C. RN-C "told the staff person to tell [LPN-R] to take the insulin off hold. I was not comfortable with that, so I texted [RN-C] and asked if the dose was right" and RN-C "said it was right, take off hold. So I did. My gut said I shouldn't have done that. I couldn't find anything

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{03000}	Continued From page 166	{03000}		

in the system [regarding orders upon return from the hospital], so I called the on-call doctor to verify the dose to be given and informed [R1] had received 24 units instead of 10 units."

On November 3, 2022, at 1:33 p.m. RN-C stated, "After coming back from the hospital [R1's] insulin was reduced due to after surgery [R1] was not eating as much. Orders were sent back with her and I asked [LPN-R] to enter [into the licensee's computer system] and fax the pharmacy. Re-entering the medication orders [into the licensee's computer system] did not happen. RNS-E stated, "Guidance if negative outcome would report. No negative outcome with glucose monitoring." RNS-E stated, "No" to the incident being reported to MAARC.

R3
R3's service plan/care plan dated August 16, 2022, included administration of medications and INR (international normalized ratio/lab calculation based on prothrombin test results; a test measuring how long it takes a blood clot to form in a blood sample) by an outside agency.

R3's Medication Error report dated June 10, 2022, indicated resident's last dose of warfarin was on Thursday, June 9, 2022. R3 was unaware that he did not receive his warfarin. The med passer informed nursing that warfarin was not on E-MAR(electronic medication administration record) to be given.

R3's Medication Administration Record (MAR) dated June 2022, identified no signatures by the staff for administration of warfarin for the dates of June 9, 10, 11, and 12, 2022.

R3's clinic notes indicated the following:

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{03000}	Continued From page 167 -dated June 8, 2022, indicated results for INR was "2.5" and anticoagulation dosing "Goal:2-3". New warfarin dosing: warfarin 1.5 milligrams (mg) Sunday; and warfarin 2.5 mg Monday, Tuesday, Wednesday, Thursday, Friday and Saturday. Recheck INR one week June 15, 2022. -dated June 13, 2022, discontinue previous warfarin orders due to missed dosing; start warfarin 5 mg daily Monday and Tuesday. Recheck INR on Wednesday June 15, 2022. -dated June 15, 2022 INR value today "1.6. Goal: 2-3". Warfarin 2.5 mg Wednesday, Thursday, Friday, Saturday, Sunday, Tuesday and 1.5 mg on Monday. Recheck INR one week June 22, 2022. R3's INR value fell below the goal of "2-3" on June 15, 2022, due to missed doses of warfarin. The licensee failed to ensure immediate report of a significant medication error to MAARC. On November 3, 2022, at 8:41 a.m. LPN-R stated even though R3's MAR showed R3 did not receive medication on the dates of June 9, 10, 11 and 12, 2022, R3 had received warfarin on June 9, 2022. LPN-R stated, "I saw from the pack dose June 9 dose was given, but the staff person was unable to sign for giving the medication because the medication was not on the EMAR." LPN-R stated R3's INR on June 8 was "2.5 and on June 15 was "1.6". LPN-R stated, "Yes, [R1's INR] dropped". LPN-R stated regarding if the medication error had been reported to MAARC, "I'm going to say no, didn't even think about it." On November 3, 2022, at 1:33 p.m. RNS-E stated regarding if the medication error had been reported to MAARC, "I'm usually involved in any VA [vulnerable adult/report] done. I don't recall one."	{03000}		

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{03000}	Continued From page 168 On January 30, 2023, at 11:47 a.m. RNS-E stated via phone during the entrance conference, "I never went back and reported anything. We did reeducation and training with staff" (since survey exited November 4, 2022). RNS-E stated, "No negative outcome [to residents] that's why not reported. I never went back and reported due to so many months prior". RNS-E stated, "Yes, anyone can report and if any questions or concerns they can bring to me". On January 30, 2023, at 1:05 p.m. community director (CD)-V was informed by the surveyor the licensee needed to report the above incidents to MAARC for R2, R1 and R3. On February 1, 2023, at 12:11 p.m. RN-D provided the MAARC reports for R2, R1 and R3 the licensee had filed through MAARC. The reports identified R2's MAARC report was filed on January 31, 2023, at 3:22 p.m.; R1's MAARC report was filed on January 31, 2023, at 4:16 p.m. and R3's MAARC report was filed on January 31, 2023, at 5:08 p.m. The licensee's Vulnerable Adult Maltreatment Prevention and Reporting policy dated August 1, 2021, indicated maltreatment was defined as neglect, abuse, and exploitation/theft. Staff who suspect maltreatment of a resident (abuse, financial exploitation, or neglect), or who has knowledge that a resident has sustained a physical injury which is not reasonably explained would "f. If the assisted living director or nurse confirms the suspicion of maltreatment, they will contact the Minnesota Adult Abuse Reporting Center (MAARC). Such report must be made no later than 24 hours after the maltreatment was first suspected."	{03000}		

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{03000}	Continued From page 169 No further information was provided.	{03000}		

Electronically Delivered

December 8, 2022

Administrator
AbiliT Holdings (Prairie Meadows) LLC
800 5th Avenue Northwest
Kasson, MN 55944

RE: Project Number(s) SL24053015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 4, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $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).

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

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

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#24053015 On, October 31, 2022 through November 4, 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 50 residents residing in the facility; of which 41 residents were receiving services under the provider's Assisted Living Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 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; (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	0 250		

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0 250	Continued From page 2 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). The findings include: During the entrance conference on October 31, 2022, at 9:58 a.m. registered nurse (RN)-C stated the licensee's employees in charge of the facility were familiar with the assisted living regulations	0 250		

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0 250	Continued From page 3 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. - 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	0 250		

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0 250	Continued From page 4 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 existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes	0 250		

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	24053	A. BUILDING: _____ B. WING _____	11/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

(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
0 250	Continued From page 5 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 authorized agent on May 31, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of January 31, 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; -orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; -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; -orientation to and implementation of the assisted living bill of rights; -infection control practices; -reminders for medications, treatments, or exercises, if provided;	0 250		

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0 250	Continued From page 6 -conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; -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, 0630, 0660, 1350, 1370, 1380, 1440, 1460, 1540, 1620, 1710, 1730, 1750, 1790, 1880, 1940, 1950, 1960, 1970 and 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		
0 430 SS=A	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and	0 430		

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0 430	Continued From page 7 (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of assisted living services (UDALSA) with the required content for one of four residents (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 started receiving services from the licensee on November 8, 2018. R2's record lacked documentation of receipt of a UDALSA. On November 3, 2022, at 12:16 p.m. regional nurse specialist (RNS)-E stated R2 had "no contract". No information for receipt of the UDALSA being provided to R2 was provided. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) policy	0 430		

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0 430	Continued From page 8 dated August 1, 2021, indicated the licensee would provide a "Uniform Disclosure of Assisted Living Services and Amenities" (UDALSA) to prospective residents prior to signing an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the	0 470		

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0 470	Continued From page 9 appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the staffing schedule was posted as required, potentially affecting the licensee's current residents, 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: The licensee held an assisted living facility with dementia care license. The facility was licensed for a capacity of 112 and had a current census of 41 residents receiving services. On October 31, 2022, at 9:30 a.m. at time of entrance, the surveyor observed the staff schedule was not posted in a central location for resident, family, or staff to reference. The Direct Care Staffing Plan dated July 1, 2022, signed by registered nurse (RN)-C, indicated "The daily work schedule will be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents,	0 470		

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0 470	Continued From page 10 volunteers, and the public. On October 31, 2022, at 11:00 a.m. during the entrance conference, RN-C stated "The staff schedule was in a binder in the staff room in the memory care unit. It was not posted for residents or families. We have talked about it, but we have not done it." The licensee's Staffing and Scheduling (4.16) policy dated August 1, 2022, read "The daily work schedule will be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. 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:	0 480		

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0 480	Continued From page 11 (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 2, 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=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the	0 485		

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0 485	Continued From page 12 following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, 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 ensure menus were made available to residents in the memory care unit. 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).	0 485		

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0 485	Continued From page 13 The findings include: MENU The licensee's menu provided for the Month of October 2022, and November 2022, lacked evidence of fruit and dairy to be included on the menu to meet the USDA guidelines as required. No beverages were listed on the menu. On November 3, 2022, at 10:23 a.m. certified food protection manager (CFPM)-Q reviewed the menus and verified the information above. CFPM-Q stated the licensee received menus from "US Foods" which had two main entrees, and she picked what would be served. CFPM-Q stated she developed the menus for the licensee from the menus provided from US Foods. MEMORY CARE UNIT The licensee failed to post a daily or weekly menu in the facility's memory care dining area and failed to offer a choice of fruit and milk product with the breakfast meal. On November 1, 2022, at 8:00 a.m. the surveyor observed breakfast served to 10 residents in the memory care unit dining area. The surveyor observed unlicensed personnel (ULP)-H serving breakfast from the breakfast cart as brought by the facility's main kitchen located outside of the memory care unit. The breakfast served included pancakes, sausage and coffee. The surveyor observed no fruit, milk or juice offered to any of the residents. The dining area lacked a posted weekly menu. On November 1, 2022, at 11:00 a.m. ULP-H stated, "There is usually one [weekly menu] posted on the kitchen refrigerator, but there was not one there at this time. The residents do not	0 485		

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0 485	Continued From page 14 see it." On November 3, 2022, at 10:23 a.m. CFPM-Q stated the main kitchen brings each meal to the memory care unit on a cart, and usually had a selection of fruit and milk included. CFPM-Q stated, "There are always strawberries and blueberries on hand. The resident assistants serve the meals in memory care, know what the residents there like and also know to come and ask. We usually throw cranberry juice, orange juice, hot chocolate and tea as choices." Regarding the required posting of menu CFPM-Q responded, "I didn't realize the menu needed to be posted there. There is a list on the kitchen bulletin board with food allergies." CFPM-Q stated a monthly menu was placed outside each resident apartment in the assisted living but not in the memory care unit. The licensee's Food Service and Menu Planning policy dated August 1, 2021, indicated the licensee would offer to provide or make available at least three 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. Additionally, menus would be prepared at least one week in advance and made available to all residents. [Licensee] will encourage residents' involvement in menu planning. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		

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0 510	Continued From page 15	0 510		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an 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 handwashing during direct cares for two of two unlicensed personnel (ULP-H, ULP-J). 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	0 510		

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0 510	Continued From page 16 of the residents). The findings include: FACIAL MASK EMPLOYEE The licensee failed to ensure employee facial masks were worn appropriately. On November 1, 2022, at 8:04 a.m. cook (C)-L and culinary coordinator (CC)-G were observed to serve residents breakfast in the main dining room. C-L's facial mask was worn below the nose with a mustache visible when in the dining room serving residents' food and when speaking to residents directly. CC-G's facial mask was worn below the nose when in the dining room serving residents food. The Centers for Disease Control and Prevention (CDC) Types of Masks and Respirators updated September 8, 2022, indicated "Whatever product you choose, it should provide a good fit (i.e., fitting closely on the face without any gaps along the edges or around the nose) and be comfortable enough when worn properly (covering your nose and mouth) so that you can keep it on when you need to." On November 1, 2022, at 12:44 p.m. registered nurse specialist (RNS)-E stated, "Yes, facial masks" were required to be worn by employees. RNS-E stated staff "should be wearing over the nose. We will go down and address with culinary." HANDWASHING R2 On November 1, 2022, at 7:38 a.m. unlicensed personnel (ULP)-H was observed to assist R2	0 510		

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with toileting. While wearing gloves, ULP-H changed R2's disposable incontinent brief and wiped R2's buttocks area. ULP-H stated to R2 "you did have a little bit of BM [bowel movement]". With the same gloves, ULP-H touched her own facial mask, assisted R2 with their pants and then removed the gloves. ULP-H applied clean gloves and assisted R2 to use mouthwash, washed R2's face, carried R2's dirty clothes out of R2's room holding the dirty clothes against her uniform, walked into the kitchen area, and then into the laundry room. ULP-H removed the gloves and walked out of the laundry room. ULP-H failed to remove gloves and wash hands after providing peri care, after removing gloves, and failed to continue R2's dirty laundry before removing from R2's apartment.

On November 1, 2022, at 12:44 p.m. registered nurse (RN)-C stated she would expect staff to wash their hands after providing peri cares. RN-C stated usually laundry was left in the resident's room until laundry day, and she was not sure why the staff person would have carried the laundry out of the room. RN-C stated she would expect staff to wash their hands before and after checking R2's blood sugar and upon entering and leaving a residents room.

R1
On November 1, 2022, at 8:36 a.m. while wearing gloves, ULP-J checked R1's blood pressure, administered R2's medications, checked R1's blood sugar, and then removed their gloves. ULP-J applied new gloves and applied R1's TED (thrombo embolic deterrent) stockings (used to reduce swelling) and walked out of R1's apartment. ULP-J failed to wash their hands before and after checking R1's blood sugar and assisting with TEDs. ULP-J stated at the time she

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was "trained" to do "with gloves on" and "no one mentioned" how to wash hands while providing the service of passing medications and checking a blood sugar.

R3
On November 1, 2022, at 7:30 a.m. the surveyor observed ULP-J enter R3's apartment, greeted him, set up his morning medications at the counter, documented on an electronic tablet, and administered his oral medications. No hand washing was observed prior to the medication set up. ULP-J applied gloves and prepared a topical cream, and assisted R3 with lowering his pants to access the area to apply cream. ULP-J assisted R3 with pulling up pants and buttoning them. ULP-J removed her gloves, discarded them and continued to document her tasks on the electronic tablet. ULP-J left R3's apartment without washing her hands, and entered another resident's apartment.

On November 1, 2022, at 12:45 a.m. RN-C stated her expectation was for all ULP to perform good hand hygiene between tasks, following glove use, when leaving a resident's apartment and before entering another resident's apartment.

The licensee's Infection Control policy dated August 1, 2021, indicated the licensee infection control program would be consistent with current guidelines from CDC for prevention control in long term care facilities, where applicable in assisted living facilities.

The licensee's Hand washing policy (8.09) dated August 1, 2021, indicated proper hand washing techniques should be used to protect the spread of infection. Hand hygiene and gloves-When conducting a procedure requiring the use of

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

(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
0 510	Continued From page 19 gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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. 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	0 550		

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0 550	Continued From page 20 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: -information about the facilities' grievance procedure; -the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances; and -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 On October 31, 2022, at 2:25 p.m. observation of the facility with regional director of operations and sales (RDOOS)-B identified no posted facility grievance procedure was observed in any area of the facility. RDOOS-B stated, "I don't think it's posted." The licensee's Complaint/Grievance Posting policy dated August 2021, indicated the licensee would post, in a conspicuous place, the information about the licensee's complaint/grievance procedure, including the required content as above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

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0 580	Continued From page 21	0 580		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity. This had the potential to affect all 41 residents receiving services under the assisted living dementia care license. 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 client'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 clients). The findings include: On October 31, 2022, at 9:58 a.m. during the entrance conference, quality management	0 580		

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0 580	Continued From page 22 meeting documentation was requested for review. Regional nurse specialist (RNS)-E stated quality management meetings were held at least quarterly by the director of the facility. RNS-E further stated the previous director was no longer employed by the licensee at the end of August, and they would "look for" documentation in the director's office. On November 4, 2022, at 1:35 p.m. regional nurse specialist (RNS)-E stated she spoke on the phone with regional director of operations and sales (RDOOS)-B and they "couldn't find" documentation for quality management meetings. The licensee's Quality Management Project policy dated August 1, 2021, indicated the licensee would have at least one documented quality management project in place at all times, and retain records of such projects for at least two years. The members of the quality council would meet, at minimum, quarterly, to conduct the quality management meeting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 620 SS=E	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	0 620		

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0 620	Continued From page 23 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) a suspected maltreatment for one of one resident (R2) and significant medication errors for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's service plan/care plan last reviewed April 15, 2022, included assistance with activities of daily living and administration of medications. R2's incident report dated August 7, 2022, indicated resident assistant (RA) witnessed a resident with a cup that contained bleach. "Resident states she drank some of it." The registered nurse (RN) on call was notified. RN asked if the resident had any signs of ingesting the bleach. The resident did not appear to have any odor of bleach on her. Poison control was called and stated that if the resident had ingested bleach, she would have burns on her mouth. The	0 620		

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resident did not have any signs of ingesting bleach. A family member was notified and did not wish to have R1 sent into the emergency room (ER). RN instructed staff to continue to monitor R1 for nausea and vomiting throughout the night. The report further indicated the laundry room door had been left open. "RN reiterated to staff the importance of keeping the laundry room door closed and lacked to keep chemicals away from resident's."

The licensee failed to ensure immediate report of the incident to MAARC.

On November 3, 2022, at 1:33 p.m. RN-C and Regional nurse specialist (RNS)-E stated the licensee's process for incidents was to fill out an incident report, notify the doctor, notify family, talk to staff and provide education. RN-C stated she had not filed a report to MAARC regarding the incident. RN-C stated R2 "did not drink bleach," as the poison control center informed if R2 had drank some of the bleach, R2 would of had "burns and blisters inside mouth." When asked if the incident had been reported to MAARC, RNS-E stated, "I don't recall this one." When asked when a MAARC report would be reported, RNS-E stated, "If negative outcome, make a MAARC report."

R1
R1's service plan/care plan dated October 20, 2022, included medication administration, insulin administration and blood sugar checks.

R1's Medication Error report dated June 14, 2022, documented by licensed practical nurse (LPN)-R, indicated she received a call from the RA informing the resident's insulin was still on hold. Most of the other medications were taken

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off hold when the resident returned from the hospital. The resident's blood sugar was 345. The RN who received the resident back to the community was contacted. "She instructed to take Lantus 24 units off hold." A phone call was placed to the doctor on call to verify how many units of insulin was to be given. The doctor on call "after review of resident hospital stay and discharge papers informs that 10 units of Lantus was to be given." The doctor was informed R1 received 24 units of Lantus at 1945 (7:45 p.m.) The doctor gave a verbal order to recheck blood sugar at 2145 (9:45 p.m.) If above 120, no further action needed tonight. Recheck on blood sugar was 249.

R1's After Visit Summary dated June 1, 2022, through June 14, 2022, indicated Lantus 10 units under the skin at bedtime. Last time this was given: 10 units on June 13, 2022, 7:00 p.m.

The licensee failed to ensure immediate report of a significant medication error to MAARC.

On November 3, 2022, at 8:41 a.m. LPN-R stated, "Yes, [R1] returned from the hospital" on June 14, 2022. LPN-R stated R1's family member "sat orders on [RN-C's] desk " and RN-C stated "she would take care of them" and "asked me to fax two to three orders to the pharmacy. I got a call [from staff person] insulin was still on hold" (in the computer system) and I informed the staff person to call RN-C. RN-C "told the staff person to tell [LPN-R] to take the insulin off hold. I was not comfortable with that, so I texted [RN-C] and asked if the dose was right" and RN-C "said it was right, take off hold. So I did. My gut said I shouldn't have done that. I couldn't find anything in the system [regarding orders upon return from the hospital], so I called the on-call doctor to

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0 620	Continued From page 26 verify the dose to be given and informed [R1] had received 24 units instead of 10 units." On November 3, 2022, at 1:33 p.m. RN-C stated, "After coming back from the hospital [R1's] insulin was reduced due to after surgery [R1] was not eating as much. Orders were sent back with her and I asked [LPN-R] to enter [into the licensee's computer system] and fax the pharmacy. Re-entering the medication orders [into the licensee's computer system] did not happen. RNS-E stated, "Guidance if negative outcome would report. No negative outcome with glucose monitoring." RNS-E stated, "No" to the incident being reported to MAARC. R3 R3's service plan/care plan dated August 16, 2022, included administration of medications and INR (international normalized ratio/lab calculation based on prothrombin test results; a test measuring how long it takes a blood clot to form in a blood sample) by an outside agency. R3's Medication Error report dated June 10, 2022, indicated resident's last dose of warfarin was on Thursday, June 9, 2022. R3 was unaware that he did not receive his warfarin. The med passer informed nursing that warfarin was not on E-MAR(electronic medication administration record) to be given. R3's Medication Administration Record (MAR) dated June 2022, identified no signatures by the staff for administration of warfarin for the dates of June 9, 10, 11, and 12, 2022. R3's clinic notes indicated the following: -dated June 8, 2022, indicated results for INR was "2.5" and anticoagulation dosing "Goal:2-3".	0 620		

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0 620	Continued From page 27 New warfarin dosing: warfarin 1.5 milligrams (mg) Sunday; and warfarin 2.5 mg Monday, Tuesday, Wednesday, Thursday, Friday and Saturday. Recheck INR one week June 15, 2022. -dated June 13, 2022, discontinue previous warfarin orders due to missed dosing; start warfarin 5 mg daily Monday and Tuesday. Recheck INR on Wednesday June 15, 2022. -dated June 15, 2022 INR value today "1.6. Goal: 2-3". Warfarin 2.5 mg Wednesday, Thursday, Friday, Saturday, Sunday, Tuesday and 1.5 mg on Monday. Recheck INR one week June 22, 2022. R3's INR value fell below the goal of "2-3" on June 15, 2022, due to missed doses of warfarin. The licensee failed to ensure immediate report of a significant medication error to MAARC. On November 3, 2022, at 8:41 a.m. LPN-R stated even though R3's MAR showed R3 did not receive medication on the dates of June 9, 10, 11 and 12, 2022, R3 had received warfarin on June 9, 2022. LPN-R stated, "I saw from the pack dose June 9 dose was given, but the staff person was unable to sign for giving the medication because the medication was not on the EMAR." LPN-R stated R3's INR on June 8 was "2.5 and on June 15 was "1.6". LPN-R stated, "Yes, [R1's INR] dropped". LPN-R stated regarding if the medication error had been reported to MAARC, "I'm going to say no, didn't even think about it." On November 3, 2022, at 1:33 p.m. RNS-E stated regarding if the medication error had been reported to MAARC, "I'm usually involved in any VA [vulnerable adult/report] done. I don't recall one." The licensee's Vulnerable Adult Maltreatment	0 620		

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0 620	Continued From page 28 Prevention and Reporting policy dated August 1, 2021, indicated maltreatment was defined as neglect, abuse, and exploitation/theft. Staff who suspect maltreatment of a resident (abuse, financial exploitation, or neglect), or who has knowledge that a resident has sustained a physical injury which is not reasonably explained would "f. If the assisted living director or nurse confirms the suspicion of maltreatment, they will contact the Minnesota Adult Abuse Reporting Center (MAARC). Such report must be made no later than 24 hours after the maltreatment was first suspected." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and	0 630		

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0 630	Continued From page 29 implement an individual abuse prevention plan that included an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 On November 1, 2022, at 8:36 a.m. unlicensed personnel (ULP)-I was observed to administer medications to R1, check R1's blood pressure, check R1's blood sugar and applied knee high TED (thrombo embolic deterrent) stockings (used to reduce swelling) to R1's lower legs/feet. R1's Individualized Abuse Prevention Assessment and Plan dated October 20, 2022, read for "is client vulnerable due to: ability to report abuse or neglect," with a response of "no"; however, the assessment indicated for "is client vulnerable due to: ability to give accurate information consistently" with response of "yes." In addition, the assessment failed to address R1's susceptibility to abuse by another individual, including other vulnerable adults.	0 630		

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0 630	Continued From page 30 R2 On November 1, 2022, at 7:31 a.m. ULP-I was observed to administer medications to R2, and at 7:38 a.m. ULP-H was observed to assist R2 with dressing, toileting and oral cares. R2's Individualized Abuse Prevention Assessment and Plan dated January 8, 2022, indicated for "is client vulnerable due to: ability to report abuse or neglect" with a response of "yes." The assessment failed to address R2's susceptibility to abuse by another individual, including other vulnerable adults. On November 3, 2022, 2:23 p.m. regional nurse specialist (RNS)-E stated, "That covers that," referring to the statement on the assessment "is client vulnerable due to: ability to report abuse or neglect" for assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults. R3 On November 2, 2022, at 7:00 a.m. ULP-I was observed to provide oral medications, topical cream to feet, compression wraps to both lower extremities, suprapubic catheter site care, urinary bag maintenance and exchange, light sponge bath and dressing assistance. R3's Individualized Abuse Prevention Assessment and Plan (IAPP) dated January 12, 2022, addressed his risk to abuse self or others, but but failed to address the susceptibility to abuse by another individual, including other vulnerable adults. R4 On November 1, 2022, at 10:55 a.m. ULP-I was observed to administer an inhaler to R4.	0 630		

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0 630	Continued From page 31 R4's IAPP dated February 18, 2022, addressed her risk to abuse self or others, but failed to address the susceptibility to abuse by another individual, including other vulnerable adults. On November 3, 2022, at 3:15 p.m. RNS-E stated the licensee viewed Section A. Areas of vulnerability, under 16. "Is client vulnerable due to: Ability to report abuse or neglect" in the IAPP, to address the residents' susceptibility for abuse by others. The licensee's Individual Abuse Prevention Plan policy (6.03) dated August 1, 2021, indicated the plan would contain an individualized review or assessment of the person's susceptibility to abuse by another individual including: other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with	0 640		

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	24053	A. BUILDING: _____ B. WING _____	11/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

(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
0 640	Continued From page 32 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 41 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 October 31, 2022, at 2:25 p.m. observation of the facility with regional director of operations and sales (RDOOS)-B identified no 911 emergency number or the required MAARC information was posted in common areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		

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0 650	Continued From page 33	0 650		
0 650 SS=B	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records included current job description for six of six unlicensed personnel (ULP-H, ULP-J, ULP-O,	0 650		

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0 650	Continued From page 34 ULP-M, ULP-P, ULP-N) 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 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: ULP-H ULP-H's date of hire was October 4, 2022. ULP-H provided direct care and services to the licensee residents. On November 1, 2022, at 7:38 a.m. ULP-H was observed to assist R2 with dressing, toileting and oral cares. ULP-J ULP-J had a hire date of March 1, 2022. ULP-J provided direct care and services to the licensee residents. ULP-O ULP-O had a hire date of September 3, 2021, and was a staff person from another facility operated by the same corporation of the licensee. ULP-M and ULP-P During the entrance conference on October 31, 2022, at 9:58 a.m. registered nurse (RN)-C confirmed the licensee utilized staff from supplemental staffing agencies to maintain staffing at the facility.	0 650		

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0 650	Continued From page 35 The licensee staff schedule provided by RN-C identified ULP-M (staff from supplemental staffing agency) was working on the floor providing direct care and services to residents on Monday, October 31, 2022, for the "a.m. shift." On November 3, 2022, at 10:00 a.m. ULP-P (staff from supplemental staffing agency) and ULP-O were observed to transfer a resident by use of an EZ stand (mechanical lift). ULP-H, ULP-J, ULP-O, ULP-M and ULP-P's records lacked a current job description, including qualifications, responsibilities and identification of staff persons providing supervision. On November 4, 2022, at 9:30 a.m. regional nurse specialist (RNS)-E stated there were "no job descriptions" in the ULP records. ULP-N ULP-N was hired on October 4, 2022, to provide direct care services. On November 1, 2022, at 10:45 a.m. ULP- N was observed to empty R3's urinary catheter bag. ULP-N's employee record lacked a current job description, including qualifications, responsibilities and identification of staff persons providing supervision. On November 4, 2022, at 9:35 a.m. RNS-E verified ULP-N's employee file lacked a job description. The licensee's Employee Records policy dated August 1, 2021, indicated employee records for each person would include current job	0 650		

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0 650	Continued From page 36 description, which includes qualifications, responsibilities,a dn identification of supervisors, if any. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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 by: Based on observation, 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.	0 660		

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0 660	Continued From page 37 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 September 15, 2022, indicated the licensee was a low risk. ULP-H Unlicensed personnel (ULP)-H had a hire date of October 4, 2022, and provided direct care and services to the licensee's residents. On November 1, 2022, at 7:38 a.m. ULP-H was observed to assist R2 with dressing, toileting and oral cares. ULP-H's record lacked documented evidence of TB screen and two step Tuberculin Skin Testing (TST) upon hire. ULP-O ULP-O had a hire date of September 3, 2021, and was a staff from another facility operated by the same corporation of the licensee. On November 3, 2022, at 10:00 a.m. ULP-O and ULP-P (staff from supplemental staffing agency) were observed to transfer a resident by use of an EZ stand (mechanical lift).	0 660		

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0 660	Continued From page 38 ULP-O's record lacked documented evidence of education for the facility's TB infection control plan for the procedures to address early recognition, isolation and referral for handling residents with suspected or confirmed active TB. ULP-M and ULP-P During the entrance conference on October 31, 2022, at 9:58 a.m. registered nurse (RN)-C confirmed the licensee utilized staff from supplemental staffing agencies to maintain staffing within the facility. The licensee's staff schedule identified ULP-M (supplemental staff) was working on the floor providing direct care and services to residents on Monday October 31, 2022, for the "a.m. shift." On November 3, 2022, at 10:00 a.m. ULP-P (supplemental staff) was observed to transfer a resident by use of an EZ stand (mechanical lift). ULP-P stated it was the first day of working in the facility and prior to working on the floor with residents, "two night shift RA's talked through residents and I took notes." ULP-P stated the staffing agency he worked for "does no training about the facility, except where to park and what door to come in." ULP-M's record lacked documented evidence of education for TB pathogenesis and transmission; signs and symptoms of active TB disease and the facility's TB infection control plan for the procedures to address early recognition, isolation and referral for handling residents with suspected or confirmed active TB. ULP-P's record lacked documented evidence of TB symptom screen; education for TB pathogenesis and transmission; signs and	0 660		

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0 660	Continued From page 39 symptoms of active TB disease and the facilities TB infection control plan for the procedures to address early recognition, isolation and referral for handling residents with suspected or confirmed active TB. On November 2, 2022 at 12:30 p.m. regional nurse specialist (RNS)-E stated she had "pulled [ULP-H] from the schedule as it was recognized [ULP-H] had not completed her tuberculin screening as required. The screening and testing was started immediately [on November 2, 2022] when it was discovered." On November 4, 2022, at 11:49 a.m. registered nurse (RN)-C and RNS-E verified ULP-H, ULP-O, ULP-M and ULP-P's records lacked evidence of the above content. ULP-N ULP-N was hired on October 4, 2022, to provide direct care services. On November 1, 2022, at 10:45 a.m. ULP-N was observed to empty R3's urinary catheter bag. ULP-'s employee record lacked evidence of the following: - TB history and symptom screening; and - TB screening On November 2, 2022, at 12:30 p.m. RNS-E stated she had "pulled ULP-N from the schedule as it was recognized ULP-N had not completed her tuberculin screening as required. The screening and testing was started immediately on November 2, 2022, when it was discovered." The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care	0 660		

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0 660	Continued From page 40 Settings" dated July 2013, and based on CDC guidelines, indicated all health care settings in Minnesota should have an up-to-date TB infection control program that included: Written TB infection control procedures; Health care worker (HCW) education. TB training is required at time of hire for all health care workers and the content should focus on basic information: TB pathogenesis and transmission, Signs and symptoms of active TB disease, and 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. An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. The licensee's Tuberculosis Screening policy dated September 25, 2022, indicated indicated staff would be educated regarding TB at the time of hire and annually. The content of the training would focus on basic information about: TB pathogenesis and transmission, Signs and symptoms of active TB disease, and the community infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing and other communicable infections. New staff would be screened for active signs of TB using the baseline TB screening tool for HCW's. New staff would have an IGRA blood test or a two-step Mantoux conducted with results documented. No further information was provided.	0 660		

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0 660	Continued From page 41 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 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 ensure a written emergency disaster plan with the required elements was developed and posted; failed to	0 680		

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0 680	Continued From page 42 ensure emergency exit diagrams were posted and provided to residents; and failed to ensure a written policy and procedure for missing residents included all required content. In addition, 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 50 residents, 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: The licensee lacked the following: - a written emergency disaster plan that contained a plan for evacuation, which addressed elements of sheltering in place, identified temporary relocation sites, and detailed staff assignments in the event of a disaster or an emergency; - posting of an emergency disaster plan prominently; - provided building emergency exit diagrams to all residents; and - Appendix Z (emergency preparedness) requirements EMERGENCY DISASTER PLAN On October 31, 2022, at 2:25 p.m. observation of the facility with regional director of operations and sales (RDOOS)-B identified no posted facility	0 680		

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0 680	Continued From page 43 emergency disaster plan. RDOOS-B stated, "I don't think it's posted." On November 2, 2022, at 10:18 a.m. regional director of operations and sales (RDOOS)-B stated the licensee's emergency disaster plan effective August 2021, "has some content" but "needs more detail." EMERGENCY EXIT DIAGRAM On October 31, 2022, at 2:33 p.m. RDOOS-B indicated they had not provided building emergency exit diagrams to all residents. On November 1, 2022, at 10:02 a.m. R1 stated, "No I haven't" regarding the licensee provided an emergency exit diagram to her. R1 stated regarding the licensee informing residents about the licensee's emergency disaster plan, "never to any of it." R1 stated, "several of us have mentioned that, but never been told." APPENDIX Z REQUIREMENTS The licensee lacked the following required information according to Emergency Preparedness: Appendix Z: - establish/maintain a comprehensive EP which describes the facility's approach to meeting health/safety/security needs of staff/residents addressing address how would coordinate with other, health care facilities (HCF), as well as community on a whole during emergency or disaster (natural, man-made, facility, etc.) and be reviewed/updated annually; - risk assessment which considered hazards like care related emergencies, cyber-attacks, normal supply of essential resources and medical supplies, should consider duration of interruptions, consider emerging infectious diseases (EIDs);	0 680		

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0 680	Continued From page 44 - document risk assessment for an all hazards approach, including EIDs as applicable, categorize the various probable risks by likelihood of occurrence, develop strategies for addressing facility and community based risks (evacuation plans, staffing surges/shortages, back-up plans); - identification of at risk population needs like maintaining independence, communication, transportation, supervision, medical care; and qualified person authorized in writing to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure based on the EP risk assessment and communication plan; - policy and procedure addressing whether evacuated or shelter in place for staff/residents for food, water, medical supplies, pharmaceutical supplies; - policy and procedure addressing alternate sources of energy to maintain temperatures to protect resident health/safety, safe and sanitary storage of provisions emergency lighting and sewage and waste disposal; - policy and procedure for a system to track the location of on duty staff and sheltered residents and if on duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure addressing safe evacuation form facility, including care and treatment needs of evacuees; staff responsibilities; primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff, and volunteers who remain in the facility; - policy and procedure addressing system of	0 680		

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0 680	Continued From page 45 medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - 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; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - develop a written communication plan; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan which includes contact information for Federal, State, tribal, regional and local EP staff; State Licensing and Certification Agency; and other sources of assistance; - communication plan which includes alternate means of communication with facility staff and Federal, State, tribal, regional and local emergency management agencies; - communication plan which includes method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4); - communication plan which includes means to providing information about the facility occupancy, needs, and it's ability to provide assistance, to the	0 680		

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	24053	A. BUILDING: _____ B. WING _____	11/04/2022

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0 680	Continued From page 46 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; - develop and maintain an EP training and testing program; - training program which includes initial training in EP policy and procedure to all new and existing staff, individuals providing services under arrangement, volunteers consistent with their expected role; provide EP training at least annually; maintain documentation of all EP training; demonstrate staff knowledge of EP; - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt form engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise On November 2, 2022, at 10:18 a.m. RDOOS-B stated regarding Appendix Z, "I've seen it and know what it is about, but haven't been around to all buildings yet". RDOOS-B stated regarding having completed the required risk assessment, "No, don't have". RDOOS-B stated regarding the content required for Appendix Z, content was "broad", "not specific", "needs more detail", was "vague" or "nothing in there" about the topic. RDOOS-B stated the licensee "still needed to train about emergency preparedness specifics for	0 680		

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0 680	Continued From page 47 facility". The licensee's Emergency Preparedness Plan Appendix Z Compliance policy dated August 1, 2021, indicated the licensee's emergency preparedness plan would include all required elements of appendix Z. The plan would be in writing and reviewed annually. The plan was based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan include four primary components:1. Risk assessment and planning; 2. Policies and procedures; 3. A communication plan; 4. Staff training and exercises/drills. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=E	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;	0 730		

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0 730	Continued From page 48 (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 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 observation, interview, and record review, the licensee failed to ensure documentation of content in the resident's record as required for five of five residents (R1, R2, R3, R4, R5). This practice resulted in a level two violation (a	0 730		

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0 730	Continued From page 49 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/care plan dated October 20, 2022, indicated R1 received services including assistance with pain, activities, Occupational/Physical therapy, bathing, meals, administration of medications, blood sugar checks, weights, vitals, TED (thrombus embolic deterrent) hose/compression stockings (used to reduce swelling) applied as ordered, assistance with ambulation long distances/stairs, fall interventions (ensure wearing proper foot wear), daily room tidy, housekeeping and trash removal. On November 1, 2022, at 8:36 a.m. ULP-I was observed to administer medications to R1, check R1's blood pressure, check R1's blood sugar and apply knee high TED stockings to R1's lower legs/feet. On November 1, 2022, at 10:02 a.m. R1 stated the services staff provided included shower one time a week. R1's Documentation Survey Report dated October 2022, lacked consistent documentation of tasks as indicated on the report for the following service/dates: -bathing/shower assist: October 11, 15	0 730		

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0 730	Continued From page 50 -ensure wearing proper footwear: October 17-31 R2 R2's service plan/care plan dated April 15, 2022, indicated R2 received services including activities, meals, assistance with transportation/appointments/shopping, pain, cardiac, bathing, grooming/oral hygiene, dressing/undressing, medication administration, weight monitoring, vitals, assistance with ambulation long distances, housekeeping, laundry, linen changes, daily bed making, fall interventions, assistance with safety in emergency situations, skin condition and bladder/bowel; would be able to maintain bladder/bowel function without assistance; is continent of bowels; is occasionally incontinent of bladder; reminders/cues to use toilet for voiding overnight; report to nurse any changes with bladder/bowel incontinence; uses incontinence products: pull-up; supply and disposal managed by resident/family/staff; dispose of used incontinent products every shift. On November 1, 2022, at 7:31 a.m. ULP-I was observed to administer medications to R2. At 7:38 a.m., ULP-H was observed to assist R2 with dressing, toileting and oral cares. ULP-H changed R2's disposable incontinent brief and wiped R2's buttocks area. ULP-H stated to R2 "you did have a little bit of BM [bowel movement]". ULP-H assisted R2 to the dining room for breakfast meal. R2's Documentation Survey Report dated October 2022, lacked consistent documentation of tasks as indicated on the report for the following service/dates: -visual checks eight (8) times per eight (8) hour shift: October 1, 7, 13, 15, 17	0 730		

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0 730	Continued From page 51 -toileting one time during the night: October 2, 8, 9,14, 17, 22, 29, 30 -housekeeping/laundry (nights wash, dry, fold laundry): October 2, 16, 30 -trash removal daily: October 6, 16 -dressing: October 1, 16 -hygiene/grooming: October 1, 16 R3 R3's record lacked documentation by the licensee's registered nurse (RN) regarding R3's left lower extremity wound measurements, condition and communication with the home health agency who managed wound care and staff instruction. R3's record lacked documentation of tasks completed. R3's untitled document identified as the service plan/careplan per facility staff dated August 16, 2022, indicated R3 received services that included bathing assistance, daily lower extremity compression wrap assistance, suprapubic catheter site care and catheter bag management, skin checks, medication administration, dressing cues with some hands-on assistance, visual checks every shift, housekeeping, and laundry. Resident receives wound care and INR (international normalized ratio/lab calculation based on prothrombin test results; a test measuring how long it takes a blood clot to form in a blood sample) by an outside agency. Wound documentation- R3 had been receiving wound care support from an outside home health agency over the past year for several wounds on his lower extremities. The surveyor observed one dressing placed on outer left foot that had a hydrocolloid dressing to	0 730		

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0 730	Continued From page 52 soften a callused-like area. R3' record included written correspondence from the home health agency with measurements of previous wounds, requests for ULP to monitor and cover area if the dressing came off, as well as documented concerns with multiple occasions where the dressing was found missing. R3's record lacked documentation by licensee's registered nurse with condition and measurements of previous wounds and lacked documentation regarding the current area that continues to require dressing changes and monitoring. On November 3, 2022, at 5:00 p.m. RN-C stated an outside agency managed R3's wound care, and cane to the facility three times per week. RN-C stated she tried to meet weekly with the home care nurse to look at R3's wounds but did not document those encounters nor details of the wound or wound care. RN-C stated she communicated changes/direction with the ULP via "the dashboard in PCC (Point Click Care) in a daily summary." When asked about how the licensee was ensuring ULP received the information, RN-C stated, "the message on the dashboard stays active for seven days and we can lengthen that time if needed." Task sheet documentation R3's Task record lacked documentation of tasks completed to include: Foam dressing to right and left heel (evening): October 2, 2022, Foam dressing to right and left heel (night): October 3, 2022, Hydrocolloid dressing to left foot (night): October 6, 12, 20, 22, 29, 2022, Laundry Sunday evening: October 2, 23, 2022,	0 730		

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0 730	Continued From page 53 Mobility: transfer resident with two staff (evening): October 2, 13, 2022, Mobility: transfer resident with two staff (night):October, 2, 5, 8, 20, 24, 27, 29, 2022, Orientation to the service plan (tasks that need to perform on my shift) evening: October 2, 2022, Orientation to the service plan (tasks that need to perform on my shift) night: October 3, 12, 19, 29, 2022, Toileting: assist resident to use the toilet as needed (evening): October 2, 13, 2022, Toileting: assist resident to use the toilet as needed (night): October 2,5, 8, 11, 20, 25, 27, 2022, Visual checks once per shift (evening): October 2, 2022, Visual checks once per shift (night): October 3, 12, 29, 2022, Output (catheter output volume) 8:30 p.m.: October 3, 13, 2022, R4 R4's diagnoses include unspecified dementia, psychotic disturbance (history of hallucinations), mood disturbance and anxiety, depression, age related osteoporosis (brittle/weak bones susceptible to fractures) with history of second lumbar vertebra compression fracture, asthma, dry eyes, hypertension (high blood pressure) and hypothyroidism (a condition with poor thyroid gland function). R4's unsigned and untitled document identified as the service plan/careplan per facility staff, last reviewed dated November 1, 2022, indicated R4 received services to include medication management, weekly bathing/showering/sponge bath assistance, grooming/oral hygiene, assistance with glasses and hearing aids,	0 730		

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0 730	Continued From page 54 dressing assistance/cues, assistance each morning and evening with TED stockings, ace wrap to lower right extremity as needed, eating encouragement, cues to use walker, safety checks (eight times per shift), toileting assistance, escort to and from dining area and activities, housekeeping, laundry and housekeeping. Additionally, R4 began receiving hospice services on August 30, 2022. R4's record lacked documentation of tasks completed to include: Compression stockings-put on (day): October 1, 2, 6, 24, 2022, Compression stockings off and wash out (evening): October 6, 2022, Dressing/undressing (day); October 1, 2, 6, 24, 2022, Dressing/undressing (evening): October 5, 6, 2022, Hygiene/grooming (day): October 1, 2, 6, 2022, Hygiene/grooming (evening): October 6, 2022, Oral care assist (day): October 1, 2, 6, 24, 2022, Oral care assist (evenings): October 5, 6, 2022, Orientation to the service plan (tasks that need to be completed) day: October 1, 2, 6, 24, 2022 Orientation to the service plan (tasks that need to be completed) evening: October 6, 2022, Orientation to the service plan (tasks that need to be completed) night: October 7, 10, 13, 16, 17, 20, 2022, Wash eyeglasses (day): October 1, 2, 6, 24, 2022, Wash eyeglasses (evening): October 5, 6, 2022, Wash eyeglasses (night): October 7, 10, 13, 16, 17, 2022, Escort to meals in memory care dining room (breakfast): October 1, 2022, Escort to meals in memory care dining room (lunch): October 1, 2022,	0 730		

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0 730	Continued From page 55 Food, diet, nutrition 7:00 a.m.: October 1, 2022, Food, diet, nutrition 9:00 a.m.: October 1, 2022, Housekeeping: October 17, 2022 On November 3, 2022, at 5:00 p.m. RN-C stated she and the licensed practical nurse attempt to monitor ULP missing task documentation from an alert that appeared on PCC dashboard. "The goal is to monitor this daily and follow up with ULP to ensure documentation is complete. This is a constant education piece for the ULP and there can be corrective action." R5 R5's record lacked the required content of a discharge summary. R5 discharged from the facility on June 27, 2022, to a skilled nursing facility for wound care needs unable to be met by the licensee. The discharge note included: reason for move out, disposition of belongings, disposition of medications (mediations logged and sent with family), pharmacy notification, activities of daily living (ADL) abilities, required notification to state related to waiver, and physician notification. R5's record lacked a discharge summary to include the required content as follows: -a summary of the resident's stay that included diagnoses, courses of illnesses, allergies, treatments and therapies, pertinent lab, radiology, and consultation results -a final summary of the resident's status from the latest assessment or review under statute 144G.70, if applicable, that included the resident status, including baseline and current mental, behavioral, and functional status -a post discharge plan that is developed with the resident and with the resident's consent, the	0 730		

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0 730	Continued From page 56 resident's representatives, with will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any postdischarge medical and non-medical services the resident will need. On November 3, 2022, at 5:30 p.m. RN-C stated she was unaware of the required contents for a discharge summary. On November 4, 2022, at 10:00 a.m. regional nurse specialist (RNS)-E provided a copy of the licensee's discharge summary sample form which included the required content. She stated this was the form that was to be used at time of discharge and would provide education to RN-C. The licensee's Resident Record-Documentation (2.25) dated August 1, 2021, indicated staff authorized to document in a resident record would do so for all medications, services, treatments, and therapies for each resident. Staff would also document other important and pertinent information related to each resident. When medications, services, treatment, or therapies are not performed per the service agreement and schedule, staff must document the reason why it was not performed or administered. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 57 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain the facility in good repair in regards to resident health and safety in accordance with maintenance and repair program. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: 1. On 10/31/2022 between 9:00 AM to 12:00 AM, survey staff observed during the walk-through the following: in the Lobby Area - extension cord in use; in the Theater Room - extension cord connected to a power strip; in RM 207 a 1-to-4 multi-tap adapter in use; in Office 2-9 an extension cord connected to a 3-to-1 adapter and a power-strip; in Office 2-9 an appliance connected to a power-strip; in the Memory Care Unit - Med Room a fridge connected to a	0 800		

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0 800	Continued From page 58	0 800		

power-strip; in RM 229 and extension cord in use; in the Staff Break Room an appliance connected to a power-strip; in the Chapel and extension cord in use.

2. On 10/31/2022 between 9:00 AM to 12:00 AM, survey staff observed during the walk-through the following: in RM 310, 2-9 Office, RM 217, and in the Activities Rm that items were stacked too high in proximity to sprinkler head(s) which could affect the operational efficiency of the device(s)

3. On 10/31/2022 between 9:00 AM to 12:00 AM, survey staff observed during the walk-through of the structure that in the Kitchen Area that sprinkler heads exhibited signs of oxidation, a sprinkler head was missing part of its water deflection blade, and heads were found to be dirty and debris laden

4. On 10/31/2022 between 9:00 AM to 12:00 AM, survey staff observed during the walk-through of the structure that in 2-16 - Sunroom - that the door is a delayed egress, but was not so labeled

5. On 10/31/2022 between 9:00 AM to 12:00 AM, survey staff observed during the walk-through of the structure that in the Memory Care Unit that an exit door was masked and not readily recognized as a point of egress

6. On 10/31/2022 between 9:00 AM to 12:00 AM, survey staff observed during the walk-through of the structure that the emergency lighted labeled #21 did not operate upon testing and that the unit located by the garage door only dimly lit upon testing.

7. On 10/31/2022 between 9:00 AM to 12:00 AM, survey staff observed during the walk-through of

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	24053	A. BUILDING: _____ B. WING _____	11/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 59 the structure that the fire extinguisher located in the elevator room was last inspected in SEPT of 2020 (MC)-F verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar 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.	0 810		

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0 810	Continued From page 60 (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed have detailed fire safety and evacuation plans and associated confirming documentation. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: 1. On 10/12/2022 between 11:15 AM to 12:15 PM, survey staff observed that no documentation was presented during documentation review to confirm that staff training and fire drills had occurred since 04/23/2021 2. On 10/12/2022 between 11:15 AM to 12:15 PM, survey staff observed that no documentation was presented during documentation review to confirm that annual resident training on evacuation procedures and protocols is being completed	0 810		

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0 810	Continued From page 61 3.On 10/12/2022 between 11:15 AM to 12:15 PM, survey staff observed that no documentation was presented during documentation review to confirm that staff are receiving initial fire and evacuation training upon hire and twice per year annual training (MC)-F verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed.	0 900		

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0 900	Continued From page 62 (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for two of four residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 R2 was admitted on November 8, 2018, and began receiving services under the Assisted Living with Dementia Care license on August 1, 2021. R2's record lacked an assisted living contract.	0 900		

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0 900	Continued From page 63 On November 3, 2022, at 12:16 p.m. regional nurse specialist (RNS)-E stated R2 had "no contract". R4 R4 was admitted on August 25, 2017, and began receiving services under the Assisted Living with Dementia Care license on August 1, 2021. R4's record record lacked an assisted living contract. On November 3, 2022, at 11:15 a.m. RNS-E stated there was no contract for R4. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
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	0 920		

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0 920	Continued From page 64 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 of two residents (R1, R3). 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, 2021, and renewed on August 1, 2022. On October 31, 2022, at 10:00 a.m. during the entrance conference, regional director of operations (RDOOS)-B confirmed the licensee held an assisted living with dementia care license. R1's Resident Agreement was signed August 8,	0 920		

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0 920	Continued From page 65 2021. R1's contract identified on the first page Resident Agreement with "assisted living" check marked and on page 2. "important contact information" indicated "facility/assisted living licensee;" and "AL [assisted living] License No [number]: 24053". The licensee's Resident Agreement being provided to all residents lacked accurate disclosure of the category of assisted living facility license held by the facility. On November 3, 2022, 2:23 p.m. regional nurse specialist (RNS)-E stated, "okay" when reviewing the contract and verifying the above. R3's Resident Agreement was signed July 30, 2021. R3's contract identified on page 1. Resident Agreement, included a check mark in the box next to Assisted Living and left the box next to Assisted Living with Dementia Care unchecked. On November 3, 2022, at 2:45 p.m. RNS-E stated "This may have been the result of someone misinterpreting the form when it was completed." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to	0 940		

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0 940	Continued From page 66 medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with	0 940		

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0 940	Continued From page 67 the required content for two of two residents (R1, R3). 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 was signed August 8, 2021. R3's Resident Agreement was signed July 30, 2021. R1 and R3's Resident Agreements indicated on page six "12. Availability of Public Funds and Resources" the licensee participated in the Housing Support Group Residential Housing Program which provided rental assistance to qualified individuals and participated in certain Home and Community-Based Service Waiver programs through the Minnesota Department of Human Services and through the county with which the community is located; however, the licensee's Resident Agreement lacked the following required content: -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required;	0 940		

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0 940	Continued From page 68 The licensee's Resident Agreement being provided to all residents lacked the above content. On November 3, 2022, 2:23 p.m. regional nurse specialist (RNS)-E stated, "okay" when reviewing the contract and verifying the above. On November 3, 2022, at 3:15 p.m. RNS-E stated, "The standard is for the resident to have two years worth of funds available. We are looking at contract content and will need to look at that as well." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
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	0 950		

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0 950	Continued From page 69 Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to designated representative on a document separate from the contract and failed to ensure the contract included required content for two of two residents (R1, R3). 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 was signed August 8, 2021. R3's Resident Agreement was signed July 30,	0 950		

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0 950	Continued From page 70 2021. R1 and R3's record lacked evidence in writing of providing the verbatim notice "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 a document separate from the contact as required. On November 3, 2022, 2:23 p.m. regional nurse specialist (RNS)-E verified all residents lacked being provided the verbatim notice as required. On November 3, 2022, at 3:15 p.m. RNS-E stated "This information is now included in new contracts and will be coming out for signing this week." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or	0 970		

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0 970	Continued From page 71 unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 50 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: The licensee had an assisted living with dementia care license effective August 1, 2021, and was renewed August 1, 2022. R1's Resident Agreement was signed August 8, 2021. R3's Resident Agreement was signed July 30, 2021. The Resident Agreement included the following: -page 16. 33. Indemnification "as a resident of the community, resident assumes the risk for resident's own safety and for the safety of	0 970		

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0 970	Continued From page 72 resident's guests and agents. Resident will indemnify and hold harmless the community, its employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the community's property, or caused wholly or in part by and act or omission of resident or resident's guests or agents." -page 16. 35. Liability "the community is not liable to resident or resident's guests for any injury, death, or property damage occurring in the apartment or on the community's premises unless such injury, death or property damage occurs as the result to community's own negligent acts or those of its employees, officers, managers, owners or agents. The community is also not liable for any injury, death or damage occurring as the result of resident's receipt of health-related, supportive or other services from third-party providers. Unless caused by one of the aforementioned excepted reasons, resident agrees to hold the community harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the apartment or on the community's premises." On November 3, 2022, at 3:05 p.m. regional nurse specialist (RNS)-E stated, "These are being removed from the new contract, currently being updated." No further information was provided. TIME PERIOD FOR CORRECTION:	0 970		

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0 970	Continued From page 73 Twenty-One (21) days	0 970		
01350 SS=D	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure supplemental staff met all requirements for personnel employed by the licensee for two of two supplemental unlicensed personnel (ULP-M, ULP-P). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on October 31, 2022, at 9:58 a.m. registered nurse (RN)-C confirmed the licensee utilized staff from supplemental staffing agencies to maintain staffing for the facility. The licensee's staff schedule provided by RN-C identified ULP-M was working on the floor providing direct care and services to residents on	01350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24053	A. BUILDING: _____ B. WING _____	11/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

(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
01350	Continued From page 74 Monday, October 31, 2022, for the "a.m. shift". On November 3, 2022, at 10:00 a.m. ULP-P was observed to transfer a resident by use of an EZ stand (mechanical lift). ULP-P stated it was the first day of working in the facility and prior to working on the floor with residents "two night shift RA's talked through residents and I took notes." ULP-P stated the staffing agency he worked for "does no training about the facility, except where to park and what door to come in." ULP-P stated he had not transferred a resident using a Hoyer lift (full body mechanical lift) but he would if needed. ULP-P stated he was going to check a resident's vital signs, including oxygen saturation (oxygen level in blood) (checked by utilizing a pulse oximeter device). On November 4, 2022, at 8:36 a.m. ULP-P was observed to check R1's blood pressure by utilizing an automatic blood pressure cuff. ULP-M and ULP-P's records lacked documented evidence the licensee had trained and determined ULP-M and ULP-P was competent for delegated tasks of EZ stand lift, Hoyer lift, utilizing pulse oximeter and automatic blood pressure wrist cuff. On November 4, 2022, at 11:49 a.m. RN-C and RNS-E verified ULP-M and ULP-P's records lacked documented evidence of training and demonstrated competency for the above delegated tasks. RN-C verified the ULP provided the above delegated tasks for resident services. RN-C verified she had not provided any training and competency to ULP-M or ULP-P for the delegated tasks.	01350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24053	A. BUILDING: _____ B. WING _____	11/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

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01350	Continued From page 75 The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations must be conducted by an RN and only unlicensed personnel who were determined competent and posses the knowledge and skills consistent with the complexity of tasks being delegated would be permitted to perform such tasks. The assisted living would have a system in place to communicate up to date information to a RN regarding current available staff and their competencies. The licensee Temporary and Contracted Staff policy dated August 1, 2021, indicated temporary supplemental staffing would only be used if they meet the same requirements required as hired employees and would be treated as if they were staff of the facility. Competency evaluation results must be obtained for unlicensed personnel who would be assigned to perform delegated nursing services. Staff must be orientated tot he individual needs of each assigned resident, the service plan, methods of documentation, and other elements required to provide home care services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01350		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

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01370	Continued From page 76 provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure four of four	01370		

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01370	Continued From page 77	01370		

unlicensed personnel (ULP-H, ULP-J, ULP-O, ULP-N) completed training prior to providing direct cares as required.

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:

ULP-H
ULP-H's date of hire was October 4, 2022.
ULP-H provided direct care and services to the licensee residents.

On November 1, 2022, at 7:38 a.m. ULP-H was observed to assist R2 with dressing, toileting and oral cares.

ULP-H's record lacked evidence the following education had been completed prior to providing direct cares:
-medication, exercise, and treatment reminders

ULP-J
ULP-J had a hire date of March 1, 2022. ULP-J provided direct care and services to the licensee residents.

ULP-J's record lacked evidence the following education had been completed prior to providing direct cares:
-medication, exercise, and treatment reminders

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01370	Continued From page 78 ULP-O ULP-O had a hire date of September 3, 2021 and was staff from another facility operated by the same corporation of the licensee. On November 3, 2022, at 10:00 a.m. ULP-O and ULP-P (staff from supplemental staffing agency) were observed to transfer a resident by use of an EZ stand (mechanical lift). ULP-O stated it was the first day of working in the facility and prior to working on the floor with residents she had "10 minutes of orientation by a night shift resident assistant" (RA). ULP-O stated she had been "trained and competency for treatments by another RN" at a different facility that was operated by the same corporation for this facility. ULP-O's record lacked evidence the following education had been completed prior to providing direct cares: -medication, exercise, and treatment reminders ULP-N ULP-N was hired on October 4, 2022, to provide assisted living services. On November 1, 2022 at 10:34 a.m. ULP-N was observed to empty R3's urinary catheter bag. ULP-N's employee record lacked evidence of employee training with required medication, exercise, and treatment reminders. On November 4, 2022 at 11:30 a.m. RNS-E stated she would need to check with the RN training coordinator, but believed this may be covered at medication administration class which ULP-N had not yet attended. No further information was provided.	01370		

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01370	Continued From page 79 The licensee's Competency Training Evaluations policy (5.02) dated August 1, 2021, read When a registered nurse or licensed health professional staff of (corporate name) delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. Training and competency evaluations for all ULP will include, medication, exercise and treatment reminders. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as	01380		

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01380	Continued From page 80 required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure four of four unlicensed personnel (ULP-H, ULP-J, ULP-O, ULP-N) completed training and competency evaluations prior to providing direct cares as required. 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: ULP-H ULP-H's date of hire was October 4, 2022. ULP-H provided direct care and services to the licensee residents. On November 1, 2022, at 7:38 a.m. ULP-H was observed to assist R2 with dressing, toileting and oral cares. ULP-H's record lacked evidence the following education and/or competency evaluation had been completed prior to providing direct cares: -observing, reporting, and documenting resident status; -training and competency for delegated tasks of CPAP (continuous positive airway	01380		

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01380	Continued From page 81	01380		

pressure)/BiPAP (bilevel positive airway pressure) equipment, oxygen use, wound care dressing changes, oxygen saturation utilizing a pulse oximetry device, and wrist blood pressure cuff.

ULP-J
ULP-J had a hire date of March 1, 2022. ULP-J provided direct care and services to the licensee residents.

ULP-J's record lacked evidence the following education and competency evaluation had been completed for delegated tasks prior to providing direct cares:
-CPAP/BiPAP equipment
-oxygen
-wound care dressing changes
-oxygen saturation utilizing a pulse oximetry device
-wrist blood pressure cuff
-administration of insulin medication via an Insulin Pen.

ULP-O
ULP-O had a hire date of September 3, 2021, and was staff from another facility operated by the same corporation of the licensee.

On November 3, 2022, at 10:00 a.m. ULP-O and ULP-P (staff from supplemental staffing agency) were observed to transfer a resident by use of an EZ stand (mechanical lift). ULP-O stated it was the first day of working in the facility and prior to working on the floor with residents she had "10 minutes of orientation by a night shift resident assistant" (RA). ULP-O stated she had been "trained and competency for treatments by another RN" at a different facility that was operated by the same corporation for this facility.

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01380	Continued From page 82 ULP-O's record lacked evidence the following education and competency evaluation had been completed for delegated tasks prior to providing direct cares: -CPAP/BiPAP equipment -orthotic braces -wound care dressing changes -wrist blood pressure cuff On November 4, 2022, at 11:49 a.m. registered nurse (RN)-C and regional nurse specialist (RNS)-E verified ULP-H, ULP-J and ULP-O's records lacked evidence of receiving training and competency for the above. RN-C verified the above delegated tasks were services being provided to residents of the facility by ULP. ULP-N ULP-N was hired on October 4, 2022, to provide assisted living services. On November 1, 2022 at 10:34 a.m. ULP-N was observed to empty R3's urinary catheter bag. ULP-N's training record lacked evidence of training with treatments to include, CPAP/Bipap, oxygen, wound care, oxygen saturations, and wrist blood pressure cuffs. On November 4, 2022, at 1:25 p.m. RN-C confirmed ULP-N's employee file lacked evidence of the above stated training for treatments. The licensee's Competency Training Evaluations policy (5.02) dated August 1, 2021, read,when a registered nurse or licensed health professional staff of (corporate name) delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability	01380		

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01380	Continued From page 83 to competently follow the procedures and perform the tasks. Additionally, training and competency evaluation for unlicensed personnel provided assisted living services must include administering medications or treatments as required. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
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 thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.	01440		

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01440	Continued From page 84 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 in which the individual begins working for the facility for one of six unlicensed personnel (ULP-J). 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-J's employee record lacked documented evidence of a registered nurse (RN) supervising ULP-J performing delegated tasks. ULP-J had a hire date of March 1, 2022. ULP-J' record included "Supervision of Personnel" sheet dated March 31, 2022; however, the supervision lacked documented evidence of observation of a delegated task by the RN. On November 4, 2022, at 11:49 a.m. RN-C and regional nurse specialist (RNS)-E verified ULP-J's "Supervision of Personnel" sheet dated March 31, 2022, lacked documented evidence of observation of a delegated task by the RN. The licensee's Supervision of Staff Delegated	01440		

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01440	Continued From page 85 Services dated August 1, 2021, indicated staff who provide delegated nursing or therapy tasks to residents would be supervised by an RN and would include observation of the staff administering the medication or treatment and the interaction with the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01460 SS=E	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of six unlicensed personnel (ULP-M, ULP-O, ULP-P) received orientation to assisted living facility licensing requirements and regulations before providing services. 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	01460		

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01460	Continued From page 86 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on October 31, 2022, at 9:58 a.m. registered nurse (RN)-C confirmed the licensee utilized staff from supplemental staffing agencies to maintain staffing for the facility. The licensee staff schedule provided by RN-C identified ULP-M (supplemental staff) was working on the floor providing direct care and services to residents on Monday, October 31, 2022, for the "a.m. shift". On November 3, 2022, at 10:00 a.m. ULP-O (staff from another facility operated by the same corporation of the licensee) and ULP-P (supplemental staff) were observed to transfer a resident by use of an EZ stand (mechanical lift). ULP-O stated it was the first day of working in the facility and prior to working on the floor with residents she had "10 minutes of orientation by a night shift resident assistant" (RA). ULP-P stated it was the first day of working in the facility and prior to working on the floor with residents "two night shift RA's talked through residents and I took notes." ULP-P stated the staffing agency he worked for "does no training about the facility, except where to park and what door to come in." ULP-P stated he had assisted residents this a.m. with applying "TEDs [thromboembolic deterrent stockings], Ace wraps [used to reduce swelling], a plastic leg brace to keep foot from turning and changed a catheter bag to a leg bag". ULP-O	01460		

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ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

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01460	Continued From page 87 stated she had been "trained and competency for treatments by another RN" at a different facility that was operated by the same corporation for this facility. ULP-M, ULP-O and ULP-P's records lacked evidence of receiving orientation to assisted living before providing services to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure.	01460		

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01460	Continued From page 88 On November 4, 2022, at 11:49 a.m. RN-C and regional nurse specialist (RNS)-E verified ULP-M, ULP-O and ULP-P had not received orientation to assisted living before providing services to residents of the licensee. The licensee's Employee Record policy dated August 1, 2021, indicated employee records for each person would include records of all training and in-service education required and/or provided including record of competency testing as required. The licensee Temporary and Contracted Staff policy dated August 1, 2021, indicated temporary supplemental staffing would only be used if they meet the same requirements required as hired employees and would be treated as if they were staff of the facility. Competency evaluation results must be obtained for unlicensed personnel who would be assigned to perform delegated nursing services. Staff must be orientated tot he individual needs of each assigned resident, the service plan, methods of documentation, and other elements required to provide home care services. The licensee's Orientation of Staff and supervisors and Content policy dated August 1, 2021, indicated all staff of the licensee providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. Orientation must be completed once for each staff person and is not transferable to another home care provider. No further information was provided.	01460		

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01460	Continued From page 89 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff completed the required amount of dementia care training in the required time frame for four of six employees (unlicensed personnel (ULP)-H, ULP-O, ULP-P, ULP-N). 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	01540		

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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:

ULP-H
ULP-H date of hire was October 4, 2022, and was observed to provide direct care to residents under the licensee's Assisted Living with Dementia Care license.

On November 4, 2022, at 11:50 a.m. regional nurse specialist (RNS)-E provided a print out of ULP-H's training and stated "This is what the training program shows".

The training list provided included the following topics for dementia; however, lacked documented hours for training and lacked signature indicating the training was completed for the following:
-safe environments for people living with dementia ad Alzheimer's disease
-activities for individuals living with Alzheimer's disease
-communicating with individuals living with Alzheimer's and dementia
-supporting and guiding individuals through dementia related behaviors
-all about Alzheimer's and dementia
-dementia training Minnesota (MN)
-principles of person centered planning MN
-communication and professional boundaries

In addition, the topics of dementia training MN, principles of person centered planning MN and communication and professional boundaries

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included the same dates for "award date and expiration date" with other topics listed above only having an "award date".

ULP-H's record lacked documented evidence of required training for required topics of assistance with activities of daily living; person centered planning and evidence a total of eight (8) hours of training was completed within 80 hours of employment start date.

ULP-O and ULP-P
During the entrance conference on October 31, 2022, at 9:58 a.m. registered nurse (RN)-C confirmed the licensee utilized staff from supplemental staffing agencies to maintain staffing for the facility.

On November 3, 2022, at 10:00 a.m. ULP-O (staff from another facility operated by the same corporation of the licensee) and ULP-P (staff from supplemental staffing agency) were observed to transfer a resident by use of an EZ stand (mechanical lift). ULP-O stated it was the first day of working in the facility and prior to working on the floor with residents she had "10 minutes of orientation by a night shift resident assistant" (RA). ULP-P stated it was the first day of working in the facility and prior to working on the floor with residents "two night shift RA's talked through residents and I took notes." ULP-P stated the staffing agency he worked for "does no training about the facility, except where to park and what door to come in." ULP-O stated she had been "trained and competency for treatments by another RN" at a different facility that was operated by the same corporation for this facility.

ULP-O and ULP-P's records lacked lacked documented evidence of required training for the

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areas of an explanation of Alzheimer's disease and other dementia's; assistance with activities of daily living; problem solving with challenging behaviors; communication skills; person-centered planning and service delivery and evidence a total of eight (8) hours of training was completed within 80 hours of employment start date.

On November 4, 2022, at 11:49 a.m. RN-C and RNS-E verified ULP-H, ULP-O and ULP-P's lacked evidence of receiving training for dementia as above.

ULP-N
ULP-N was hired on October 4, 2022, to provide assisted living services.

On November 1, 2022 at 10:34 a.m. ULP-N was observed to empty R3's urinary catheter bag.

ULP-N's employee record did not indicate a total of eight hours of the required dementia training was completed within 80 hours of the employee's start date. ULP-N's employee record indicated the employee had completed 7.5 hours.

On November 4, 2022 at 11:50 a.m. RNS-E provided a print out of employee training stating, "This is what the training program shows" and ULP-N lacked the required eight hours of dementia training within 80 working hours.

The licensee's Dementia Training policy (5.03) dated August 1, 2021, read Direct care employees will complete eight (8) hours of initial training within 80 hours of the employment start date.

No further information was provided.

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01540	Continued From page 93 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in 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 90-day reassessment and monitoring and change	01620		

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01620	Continued From page 94 in condition (falls, status changes, wounds, emergency room (ER) visits) for five of five residents (R1, R2, R6, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included mild cognitive impairment (memory loss), Type 2 diabetes mellitus (too much sugar in the blood) and hypertension (high blood pressure). R1's service plan/care plan dated October 20, 2022, indicated R1 received services including assistance with pain, activities, Occupational/Physical therapy, bathing, meals, administration of medications, blood sugar checks, weights, vitals, TED [thromboembolic deterrent] hose/compression stockings (used to reduce edema) applied as ordered, assistance with ambulation long distances/stairs, fall interventions, daily room tidy, housekeeping and trash removal. On November 1, 2022, at 8:36 a.m. unlicensed personnel (ULP)-I was observed to administer medications to R1. 90 DAY COMPREHENSIVE ASSESSMENT	01620		

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01620	Continued From page 95 The licensee failed to ensure 90-day resident reassessment and monitoring was comprehensive. R1's 90-day Review dated September 7, 2022, included a review of diagnoses, are orders current, medications (adverse side effects, effectiveness, indications of use, side effects, contraindications, allergies, adverse reactions or concerns of diversion of medications, storage), has there been changes in activities of daily living (ADL) since last review "no changes to ADL's", client monitoring (staff or family member present), services reviewed as per service plan and recap of health status since last review indicated "resident has had one fall this review period. Has meds managed by [licensee]. Is independent with ADL's and ambulation. She eats meals in the main dining room. Is active in the community and attends the activities of her choosing. She is not an elopement risk, no skin concerns at time of the interview. She has had med changes to her insulin and Glipizide to manage her diabetes, along with Lyrica and oxycodone to manage her pain." R1's 90-day review lacked inclusion of required areas of the uniform assessment tool (comprehensive assessment) and documented evidence of a physical assessment by the RN (vital signs, lung sounds, pain, etc.). CHANGE IN CONDITION COMPREHENSIVE ASSESSMENT R1's record lacked comprehensive assessment by the RN for change in condition related to change in physical status/falls. R1's Progress Notes/incident reports identified falls, change in physical status or emergency	01620		

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room (ER) visit for the following dates:
-May 18, 2022, documented by RN-C, resident taken to ER by family member at request of NP [nurse practitioner]. She will be admitted for monitoring and tests.
-May 20, 2022, documented by RN-C, resident assistant (RA) reports resident's blood sugar was 440 and 418 and asked is she could do anything differently with medications. Informed RA we cannot do anything differently as we do not have orders. Resident states she had pasta salad and fruit to eat today. Writer informed this may be contributing to high blood sugar. Writer asked RA to call back if resident begins to feel unwell. RA will check on resident later this evening to be sure resident is feeling okay and let nursing know if resident is having any symptoms of hyperglycemia (high blood sugar).
-August 28, 2022, at 14:00 (2:00 p.m.) resident states she was trying to get water and legs started to give out. Went down to her knees and then to her buttocks. Vitals were taken and RN was called. No injuries, so RN instructed to RA to assist resident to her feet.
-August 29, 2022, documented by licensed practical nurse (LPN)-R. Follow up fall on August 8, 2022. Resident states she feels tired, very weak and shaky. No complaints of pain. Resident has requested assitance to restroom due to weakness.
-September 30, 2022, 11:09 a.m. documented by LPN-R. RA informs resident stated she attempted to stand from her recliner chair, became dizzy and fell back into the chair. This writer did go speak with resident. Resident has been more tired over the last week. Resident states that yesterday she had a large bowel movement that was black and sticky like tar. She states that the doctor had been keeping an eye on her hemoglobin, but has not had her blood checked

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for a while now. Call placed to (family member) who reports September 1st was the last time doctors checked resident's blood. Family member will call doctor and call back. At 3:51 p.m. phone call received, NP will see resident on Monday and have lab draw. Resident to increase fluid intake over the weekend. If condition worsens resident should be seen in ER.
-October 3, 2022, at 15:00 (3:00 p.m.) documented by LPN-R. Resident on floor. Resident states she was going to sit in her chair and as she was turning lost her balance and fell. Walker was across room where she parks it. No shoes on feet. Nursing was requested to go to room. No complaints of pain. Range of motion baseline. Resident has small abrasion, not bleeding, to her right eye brow where glasses bumped her when she fell. Intervention: NP will review medication list and will order physical/occupational therapy evaluations.
-October 4, 2022, documented by LPN-R, follow up fall on October 3, 2022. Resident is up and walking around apartment without walker. She was encouraged to use her walker. No complaints of pain related to fall. She is waiting to hear if primary care physician is going to change her medications. No concerns at this time.
-October 16, 2022, at 13:03 (1:03 p.m.) "RA staff alerted on call nurse" unwitnessed fall in apartment. Resident states she was getting up to get some water, got dizzy and fell. No injuries. Reported resident did not eat much so far today; this may have attributed to her dizziness.
-October 17, 2022, documented by LPN-R, follow up fall on October 16, 2022. Resident in recliner chair eating breakfast. Her lower legs and feet have "2+" (two plus) pitting edema. Resident does recall falling yesterday. No complaints of pain. She looks tired. Resident states she feels like she did when she had her stroke a while ago.

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She states the NP to see her this morning. Resident's (family member) arrived and has questions about medications and will be speaking to NP about. Resident stable when this writer left room.

The following assessments for R1, documented completed by RN-C were provided:
-dated June 14, 2022, Comprehensive (readmission from hospital)
-dated June 14, 2022, Medication/Treatment/Therapy Assessment and Plan
-dated June 14, 2022, Individual Abuse Prevention Plan
-dated June 14, 2022, Mental Status Questionnaire
-dated June 14, 2022, Fall Risk Assessment
-dated September 7, 2022, 90 Day Review
-dated September 7, 2022, Medication/Treatment/Therapy Assessment and Plan
-dated October 20, 2022, Fall Risk Assessment
-dated October 20, 2022, Comprehensive
-dated October 20, 2022, Medication/Treatment/Therapy Assessment and Plan
-dated October 20, 2022, Individual Abuse Prevention Plan

Although interventions were implemented following falls, R1's record lacked documented evidence of comprehensive assessment by the RN for change in condition related to falls and physical change in status.

On October 31, 2022, at 9:58 a.m. RN-C and regional nurse specialist (RNS)-E stated nursing assessments were completed pre-admit, day of move in, within 14 days, every 90 days, annually,

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01620	Continued From page 99 change of condition and readmission. On November 3, 2022, 2:23 p.m. RN-C stated she saw R1 after falls. RN-C stated changes were made with R1's medications and R1 had a melatonin test (assesses two major causes for inability to sleep) completed. RN-C verified R1's record lacked documented evidence of her going to see R1 after a fall. RN-C stated comprehensive assessments were completed annually and if a resident is gone longer than 24 hours with an ER visit. RN-C and RNS-E stated a comprehensive assessment was not done with 90 days. RN-C stated she does not complete a physical assessment (take vitals, listen to lung sounds) typically when completing assessments, but does review vital signs recorded. RN-C and RNS-E verified R1's record lacked documented evidence of RN comprehensive assessment with changes in condition. R2 R2's diagnoses included Alzheimer's disease. R2's service plan/care plan dated April 15, 2022, indicated R2 received services including bladder/bowel, would be able to maintain bladder/bowel function without assistance. Is continent of bowels. Is occasionally incontinent of bladder. Reminders/cues to use toilet for voiding overnight. Report to nurse any changes with bladder/bowel incontinence. Uses incontinence products: pull-up. Supply and disposal managed by resident/family/staff. Dispose of used incontinent products every shift. On November 1, 2022, at 7:38 a.m. ULP-H was observed to assist R2 with dressing, toileting and hygiene.	01620		

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01620	Continued From page 100 90 DAY COMPREHENSIVE ASSESSMENT The licensee failed to ensure 90-day resident reassessment and monitoring was comprehensive. R2's 90-day Review dated July 8, 2022, included a review of diagnoses, are orders current, medications (adverse side effects, effectiveness, indications of use, side effects, contraindications, allergies, adverse reactions or concerns of diversion of medications, storage), has there been changes in activities of daily living (ADL) since last review "ISP [individual service plan] remains current at this time", client monitoring (staff or family member present), services reviewed as per service plan and recap of health status since last review indicated "since last review resident has not had any falls or illnesses. She has escorts to meals and activities outside of [locked unit]. She is independent with ADL's with checks to ensure ADL's are completed, clothing clean and appropriate. She enjoys spending time socializing with other resident in [locked unit]/Also enjoys attending live to be healthy when it is offered. She is independent with ambulation at this time." R2's 90-day Review dated September 30, 2022, included a review of diagnoses, are orders current, medications (adverse side effects, effectiveness, indications of use, side effects, contraindications, allergies, adverse reactions or concerns of diversion of medications, storage), has there been changes in activities of daily living (ADL) since last review "ISP [individual service plan] remains current at this time", client monitoring (staff or family member present), services reviewed as per service plan and recap of health status since last review indicated "since last review, resident has had 1 fall and no	01620		

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illnesses. She has escorts to meals and activities outside of [locked unit]. She is independent with ADL's with checks to ensure ADL's are completed, clothing clean and appropriate. She enjoys spending time socializing with other resident in [locked unit]/Also enjoys attending live to be healthy when it is offered. She is independent with ambulation at this time. Resident affect remains unchanged and she is stable."

R2's 90-day reviews as above, lacked inclusion of required areas of the uniform assessment tool (comprehensive assessment) and documented evidence of a physical assessment by the RN (vital signs, lung sounds, pain, etc.).

CHANGE IN CONDITION COMPREHENSIVE ASSESSMENT
R2's record lacked comprehensive assessment by the RN for change in status.

R2's Progress Notes/incident report/physician progress note identified change in status for the following dates:
-dated August 7, 2022, incident report indicated resident assistant (RA) witness resident with a cup that contained bleach. "Resident states she drank some f it." Registered nurse (RN) on call was notified. RN asked if resident had any signs of ingesting the bleach. Resident does not appear to have any odor of bleach on her person. Poison control was called and stated that if the resident had ingested bleach she would have burns on her mouth. Resident does not have any signs of ingesting bleach. family member was notified and does not wish to have R1 sent into the emergency room (ER). RN instructed staff to continue to monitor R1 for nausea and vomiting throughout the night. The report further indicated

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the laundry room door had been left open. "RN reiterated to staff the importance of keeping the laundry room door closed and lacked to keep chemicals away from resident's."
-dated August 8, 2022, progress note documented by RN-C was a recap of the above incident report dated August 7, 2022.
-dated August 8, 2022, progress note documented by LPN-R, follow up for incident August 8, 2022. Resident is up and about in memory care as per her usual self. No complaints of pain/discomfort of mouth or stomach. Resident is at her baseline.
-dated October 11, 2022, documented by LPN-R, resident is not herself today. She is more sleepy and slow to move. This is different for her as she usually is up and moving about in memory care. Staff reports she is unsteady on feet. Resident states she feels weak and tired. Vital signs documented. Grasp in both hands are equal but weak. NP notified thru portal.
-dated October 14, 2022, Evaluation and Management physician note indicated "full incontinence of feces. Staff noting patient to have more instances of fecal incontinence. Has historically been independent in the restroom, but is requiring more cares of lately."

The following assessments for R1, documented completed by an RN were provided:
-dated January 8, 2022, Comprehensive
-dated January 8, 2022, Individual Abuse Prevention Plan
-dated July 8, 2022, 90-Day Review
-dated September 30, 2022, 90-Day Review
-dated September 30, 2022, Medication/Treatment/Therapy Assessment and Plan

R2's record lacked documented evidence of

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comprehensive assessment by the RN for change in condition related to change in status.

On November 3, 2022, at 1:33 p.m. RN-C stated R2 "did not drink bleach" as the poison control center informed if R2 had drank some of the bleach R2 would of had "burns and blisters inside mouth".

On November 3, 2022, 2:23 p.m. RN-C stated she was not aware of the physician note dated October 14, 2022, indicating R2 was requiring more assistance due to bowel incontinence. RN-C verified an assessment of R2 was not completed for the change in condition related to bowel incontinence. RN-C and RNS-E verified R2's 90-day assessment were not comprehensive and R2's record lacked comprehensive assessment by an RN for changes in status as above.

R6
R6's record lacked comprehensive reassessment and monitoring by the RN for a change in condition related to falls and change in status.

R6's diagnoses included epidemic vertigo (a sensation of whirling and loss of balance), mild cognitive impairment and legal blindness.

R6's service plan/care plan dated March 31, 2022, indicated R6 received services including activities, pain management, assistance with bathing, grooming/hygiene, dressing/undressing, eating/meals, medication administration, treatments/therapies, toileting, mobility, safety, falls (ensures has pendent on person during visual checks, remind to call for assitance, to wear grippy socks at night, safety checks eight times per shift, urinary analysis/culture to be

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considered by primary care physician), home management. In addition, R6 was receiving Hospice services from an outside agency.

R6's record identified R6 had six falls between the dates of August 3, 2022, and October 15, 2022.

R6's Progress Notes/incident reports identified the following for the following dates:
-August 3, 2022, incident report, fall going to bathroom. No injuries. RN called, vitals taken and resident guided with assist of one to get up.
-August 3, 2022, progress note documented by RN-C, resident is in chair and is having coffee and cookies in dining room. Has no complaints of pain or apparent residual effects from fall this morning.
-August 25, 2022, incident report, staff heard resident yelling for help. Staff found resident lying on bathroom floor between wheelchair and toilet. RN on site notified. Vitals were taken. Resident was assessed for injuries. No injuries.
-August 26, 2022, progress note documented by LPN-R, resident up in wheelchair for lunch. Offers no complaints of pain. Does not remember falling in bathroom when she self toileted. No injuries noted. No concerns at this time.
-September 3, 2022 incident report, RA was passing by apartment and heard resident yelling. Upon entering the bathroom resident was observed on the floor. Resident denies pain and denies hitting head. On call nurse notified.
-September 3, 2022, progress note documented by LPN-R, follow up fall. Resident does not remember falling. No new complaints of pain related to fall. No new concerns at this time.
-September 27, 2022, progress note documented by RN-C, writer and LPN called to resident room. Resident observed to be vomiting and having a

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hard time speaking. Strength is equal on both sides on assessment. Slight right side facial droop. Hospice notified. Writer requested hospice order medication for nausea.
-October 7, 2022, incident report, at the time of safety check resident was seen sitting on floor by her bed. Wheelchair was close and brakes were not locked. Resident stated she was going to go to the bathroom. On call nurse notified. Bruise right forearm. Intervention: ensure brakes on wheelchair remain locked and wheelchair is close to bed after resident gets into bed.
-October 12, 2022, progress note, RA staff called on call nurse to report resident had fall. She was on floor sitting next to bed. No injuries. Denies hitting head. Hospice was called and they will send nurse out to see resident.
-October 12, 2022, progress note documented by RN-C, resident is resting comfortably in her room. No complaints of pain. Hospice RN was here to see her this morning. He had no concerns.
-October 15, 2022, incident report, RA alerted on call nurse that resident has an unwitnessed fall. She had been sitting in her chair in bedroom and it appears she slid out of it onto the floor. Staff had just been present in room 10-15 minutes prior to this and they have been trying to transition resident into bed throughout the overnight. The RA reports there appears to be a bump on left side of head approximately the size of a quarter. No visible bleeding or injury. No loss of consciousness. She is not reporting any pain.
-October 17, 2022, progress note documented by LPN-R, follow up fall on October 15, 2022. resident up in wheelchair today and is her cheery self. Resident offers no complaints of pain and no bump is seen nor felt by this writer. Resident appears to be at her baseline mentally and physically.
-October 17, 2022, progress note documented by

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01620	Continued From page 106 RN-C, No complaints of pain and is at her baseline today. She is in good spirits and does not recall falling. No apparent residual effects. R6's record indicated assessments by the RN were completed as follows: -October 12, 2022, 90-day review (not comprehensive) -October 12, 2022, Medication/Treatment/Therapy Assessment and Plan R6's record lacked evidence the RN had conducted comprehensive assessment of the resident for a change in status and condition related to falls, including review of causative factors and implementation of interventions to minimize the risk for future falls and potential injury. On November 3, 2022, at 1:54 p.m. RN-C stated, "A lot of times [R6] tries to get up to go to the bathroom by herself and that's the cause of her falls". RNS-E reviewed R6's record and stated "I don't see anything" regarding documentation of interventions implemented related to the above falls. RNS-E stated the only documented assessments completed for the time frame of falls (as above) were dated October 12, 2022, and what was documented in the progress notes as above. R3 The licensee failed to complete a comprehensive assessment for a change in condition with R3's Emergency Room (ER) visit, failed to include wound descriptions in R3's assessments and failed to complete a comprehensive assessment every 90 days using the uniform assessment tool	01620		

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01620	Continued From page 107 as required. R3's service plan/care plan dated August 16, 2022, indicated R3 received services that included bathing assistance, daily lower extremity compression wrap assistance, suprapubic catheter site care and catheter bag management, skin checks, medication administration, dressing cues with some hands-on assistance, visual checks every shift, housekeeping, and laundry. Resident receives wound care and INR (international normalized ratio/lab calculation based on prothrombin test results; a test measuring how long it takes a blood clot to form in a blood sample) by an outside agency. R3's diagnoses included heart failure, atrial flutter on warfarin (blood thinner to prevent blood clots), peripheral vascular disease (a condition where there is poor blood circulation to extremities), chronic kidney disease, benign prostatic hyperplasia with urinary retention and lower urinary tract symptoms (enlarged prostate causing poor bladder emptying), presence of suprapubic urinary stoma/catheter (opening to the bladder through the abdomen for urinary catheter placement), polyosteoarthitis (multiple locations of arthritis). On November 2, 2022, at 7:00 a.m. ULP-S was observed to provide oral medications, topical cream to feet, compression wraps to both lower extremities, suprapubic catheter site care, urinary bag maintenance and exchange, light sponge bath and dressing assistance. The surveyor observed a small hydrocolloid dressing on left outer foot dated November 1, 2022. ULP-Q stated "The home health agency manages the dressing, there's an area on the	01620		

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side of his [R3] foot they are trying to soften, kind of like a callus or something. His other wounds have healed and they are working with just this one now." When surveyor asked what the ULP role was with the hydrocolloid dressing, ULP-Q stated, "We just make sure it's there and if it's not there's a corn pad in his cupboard we put on. The home health nurse comes and takes care of it otherwise."

ER visit
R3's provider note dated May 20, 2022, indicated R3 had been sent to the emergency room (ER) on May 15, 2022, for epistaxis (bloody nose) and hematuria (blood in the urine). R3 was found to have an INR (blood clotting level usually between 2-3) of 13.5. It was determined R3 had received miscalculated warfarin dosing. R3 received 6.5 mg warfarin and should have received 2.5 mg. R3's warfarin dosing was managed by a home health agency. R3 was also diagnosed with acute cystitis (bladder infection). In the ER, R3 was given 10 milligrams (mg) of vitamin K to aid in correcting the INR level. The INR on May 20, 2022, had returned to 2.5 (within the normal range of 2-3). R3 was to continue a course of cefdinir (antibiotics) through May 24, 2022.
The licensee failed to complete a comprehensive assessment with this ER visit, out of range INR, and diagnosed acute cystitis.

On November 3, 2022, at 5:00 p.m. RN-C and RNS-E stated the licensee did not have the practice of completing a comprehensive assessment if residents were not admitted to the hospital or if they are gone for less than 24 hours. RN-C stated "If it happened today, I would know he [R3] needed to have a comprehensive assessment."

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01620	Continued From page 109 Assessments The licensee failed to complete details of R3's wounds to include wound description, measurements and treatment information. R3's record included assessments dated July 12, 2022, and October 5, 2022. R3's assessment dated July 12, 2022, labeled MN (corporate initials) 90 day review. Section 2. Recap of health status since last review (falls, antibiotics, med changes, affect, illness, elopement, skin etc) read "Resident has not had any falls since last review. Wounds on heel and toe have improved greatly. Resident has had changes to Miralax, hydrocortisone to foreskin, and Coumadin based on INR. His affect is good. He is not an elopement risk." R3's assessment dated October 5, 2022, labeled MN (corporate initials) 90 day review. Section 2. "Resident has not had any falls since last review. Wounds on heel and toe have improved greatly. Resident had changes to Coumadin based on INR. His affect is good. He is not an elopement risk." Assessments dated July 12, 2022 and October 5, 2022, included the following content: A. 14 day review -resident requests for medication management -list of all diagnoses -Top two to three diagnoses related to current health status -Recap of health status since last review -Progress on previous recommendations -Orders current Yes/No -Review of medications (side effects, indications of use, contraindications, allergies, adverse reactions or concerns of diversion of medications. Yes/No -Note adverse side effects and effectiveness of	01620		

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01620	Continued From page 110 medications -Are medication orders current and meds administered accordingly Yes/No -Medication reviews-RN review every 30 days and as needed, provider reviews every 365 days and pharmacy reviews meds every quarter Yes/No -Medications in a locked cupboard/drawer in the resident apartment or med cart Yes/No -Have there been changes in the activities of daily living listed on the ISP (individual service plan) since last review -Recommendations/Additional notes B. Client monitoring -Presence of unlicensed staff Yes/No -Family Member present Yes/No -Services reviewed as per Service Plan (Appropriate/Not appropriate/Not applicable) -Quarterly care conference held with resident/responsible party/other important individuals in the resident's life. (how meeting was managed) -ISP review completed -Yes The Licensee failed to include all of the content in the uniform assessment tool. On November 3, 2022, at 3:20 p.m. RN-C verified she had not included measurements or description of R3's wounds in all of her assessments and had not documented weekly measurements. She also stated she uses the 90 assessment tool the corporate office provided which was an abbreviated version of the uniform assessment tool. RN-C stated she used the uniform assessment tool at time of admission, with a resident's change in condition, and annually. RN-C stated, "If it's not a change in condition, it's usually a quick visit. I go see them, call family about concerns and note medication	01620		

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01620	Continued From page 111 changes, falls, illnesses and affect. When asked about completing a full assessment, RN-C stated, "No, more to see if anything is cooking and any change in services. I look at vital signs in charts which are done monthly by ULP." R4 The licensee failed to complete a comprehensive assessment with a change in condition following two ER visits, with the initiation of hospice services, following a positive COVID-19 test and failed to include the required content in the uniform assessment tool. R4's service plan/care plan dated November 1, 2022, indicated R4 received services to include medication management, weekly bathing/showering/sponge bath assistance, grooming/oral hygiene, assistance with glasses and hearing aids, dressing assistance/cues, assistance each morning and evening with TED (thromboembolic deterrent) stockings, ace wrap to lower right extremity as needed, eating encouragement, cues to use walker, safety checks (eight times per shift), toileting assistance, escort to and from dining area and activities, housekeeping, laundry and housekeeping. Additionally, R4 began receiving hospice services on August 30, 2022. R4's diagnoses include unspecified dementia, psychotic disturbance (history of hallucinations), mood disturbance and anxiety, depression, age related osteoporosis (brittle/weak bones susceptible to fractures) with history of second lumbar vertebra compression fracture, asthma, dry eyes, hypertension (high blood pressure) and hypothyroidism (a condition with poor thyroid gland function).	01620		

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01620	Continued From page 112 On November 1, 2022, at 10:55 a.m. ULP-I was observed to administer an inhaler to R4. R4's record included the following licensee progress notes: -August 10, 2022, at 9:26 a.m. by RN-C "Since last review, resident has not had any falls. No (sic) not note any recent illness infections or use of antibiotics. Resident pleasant during visit, affect appropriate. Resident resides in memory care at this time and does not appear to be an elopement risk. Skin intact per staff report." -August 10, 2022, 11:51 a.m. by RN-C, "Resident c/o [complained of] severe back/stomach pain. Refuses to get out of bed to get dressed or eat. Contacted daughter who would like her transported via EMS [Emergency Medical Services] to be evaluated in the ER." -August 10, 2022, 7:33 p.m. by licensed practical nurse (LPN)-R, "Resident will be returning to p.m. yet this evening. Resident has been dx [diagnosed] with UTI [urinary tract infection] and will be treated with antibiotics BID [twice daily] for five days. Resident was given first dose of antibiotic at hospital. Daughter will ensure that resident receives morning dose tomorrow until [pharmacy name] delivers the antibiotic. Staff updated on resident status and expected return." -August 12, 2022, at 12:35 p.m. by LPN-R, "RA [resident assistant-ULP] requested nursing to go to resident room. Resident is lying on her bed thrashing from her side to her back She is trying to take sheets of her bed, is asking where people were at and said she needed help getting right here as she patted the top of the mattress. This writer and a RA are at the side of bed so she does not roll out of bed. RN requested to come to room. RN states this was the condition the resident was in when she was sent to the ER two[2] days ago and was DX [diagnosed] with a	01620		

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ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

(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
01620	Continued From page 113 UTI." -August 12, 2022 at 6:49 p.m. by LPN-R, "Received phone call from St. Mary's ER. Resident continues to have UTI. All other results are normal. Resident did receive dose of IV [intravenous] Rocephin and is doing better. Resident also has lidocaine patch applied to lower back and will need to be removed in the morning. P.M. nursing to contact primary care provider for prescription for lidocaine patch. Resident will be returning to p.m. with daughter transporting. Paper work will be sent with daughter. It is advised that resident continue taking antibiotic given Wednesday until gone with next does to be in the morning. P.M. staff notified that resident will be returning to facility this evening." -August 30, 2022, by LPN-R, "Hospice intake nurse here today to assess resident and speak with daughter. Resident admitted to [hospice name]. Bed will be coming today." -September 13, 2022, by RN-C, "Resident tested positive for COVID-19 today. Daughter, [hospice name], and [provider name] notified." R4's record included provider's notes with the following dates and information: -August 12, 2022, Follow up ED (Emergency Department) visit for UTI (urinary tract infection)-history of present illness" Acute cystitis (bladder inflammation related to infection) without hematuria (no blood in urine). Was sent to ED on August 10, 2022, with extreme back pain and abdominal pain. Determined to have UTI and started on five day course of cefinir (antibiotic), sent back same day. Nursing reports has spent all day yesterday sleeping and is asleep for today's visit. Single subsegmental pulmonary embolism without acute cor-pulmonale (single blood clot in the lung not causing heart	01620		

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01620	Continued From page 114	01620		

problems). This was an incidental finding with an abdominal CT scan. Given patient had no shortness of breath and her vital signs were stable, no new orders of medications were attempted. Wedge compression fracture of second lumbar vertebra (initial). Age indeterminate compression fractures of second and third lumbar in abdominal CT. patient does not routinely complain of back pain and no recent falls recorded. Has as needed Tylenol if necessary. Instructions included: Finish antibiotic course. Encourage water hydration between meals. Regarding pulmonary embolism, monitor for shortness of breath, hemoptysis (bloody secretions with cough), or unstable vital signs. Regarding wedge compression fracture: continue current supportive measures.
-August 19, 2022, provider note read "Follow up of second ED visit for back pain and altered mental status. Is now receiving Tylenol around the clock and lidocaine patches at bedtime. Is sleeping comfortably today. Delirium due to known physiological condition. Sent back to the ED for altered mental status. Resident is lying on her bed thrashing from her side to her back She is trying to take the sheets off her bed. is asking where people were at and said she needed help "getting right here" patted the top of the mattress. In ED, was recommended to obtain script for back pain but no other treatments completed. Patient discharge same day back to facility. Today is in bed asleep, no evidence of repeated delirium, but does have Seroquel as needed."
-August 30, 2022- Hospice start of care which included certification by the hospice provider and the resident's provider stated R4 was terminally ill with a life expectancy of six months or less if the disease process runs its normal course.

R4's record included 90-day assessments with

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01620	Continued From page 115 dates of May 10, 2022, August 10, 2022, and September 22, 2022. -August 10, 2022, assessment appeared to have been completed prior to R4's ER trip later that day. The assessment lacked evidence of an ER visit or concerns leading to an ER visit. Additionally, the licensee failed to complete an assessment with a change in condition for both ER visits (August 10, 2022 and August 12, 2022). -September 22, 2022, assessment indicated reason for assessment was "Admit to hospice." This assessment included the elements in the uniform assessment tool, but the licensee failed to complete it timely with the change of condition on the date of hospice enrollment. R4's 90-day assessments dated May, 10, 2022 and August 10, 2022, lacked the required content of the uniform assessment tool. On November 3, 2022, at 5:30 p.m. RN-C and RNS-E stated the licensee did not have the practice of completing a comprehensive assessment if residents were not admitted to the hospital or if they are gone for less than 24 hours. RN-C and RNS-E verified R4's record lacked the change in condition assessments with R4's ER visits, hospice enrollment and COVID-19 positive testing. RN-C stated, "I see now that I should have done the full assessments with the changes in condition." The licensee's Assessments, Reviews and Monitoring policy (6.01) dated August 1, 2021, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated and signed by the registered nurse who conducted the assessment. Resident reassessment and	01620		

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01620	Continued From page 116 monitoring must be conducted no more than 14 calendar days after the 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. Quarterly assessments, not exceeding 90 calendar days, may be performed by a licensed practical nurse as a focused assessment if no resident changes are noted. The individualized review or subsequent reviews must include all the required elements as specified in Rule, conducted in person, be in writing, dated and signed by the registered nurse who conducted the individualized review. The licensee's Falls Prevention and Reduction policy dated October 15, 2022, indicated based on the nurse's initial assessment of the resident and any re-assessments as needed, if the nurse believes the resident has a risk for falls, the nurse would conduct a falls assessment, evaluate potential interventions to reduce or eliminate the risk, educate the resident and/or the resident's representative and make recommendations for preventative actions the resident can take, such as physical therapy, exercise, etc. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living	01640		

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01640	Continued From page 117 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 three of four resident (R2, R3, R4) service plans were revised to reflect the current services provided. In addition, the facility failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services provided for one of four residents (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	01640		

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01640	Continued From page 118	01640		

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

The findings include:

R2
R2's record lacked evidence of revision of the service plan with change in services.

R2's diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions).

R2's service plan/care plan dated April 15, 2022, indicated R2 received services including bladder/bowel, would be able to maintain bladder/bowel function without assistance. Is continent of bowels. Is occasionally incontinent of bladder. Reminders/cues to use toilet for voiding overnight. Report to nurse any changes with bladder/bowel incontinence. Uses incontinence products: pull-up. Supply and disposal managed by resident/family/staff. Dispose of used incontinent products every shift. R2's service plan/care plan did not address meals.

R2's 90 Day Review assessment dated July 8, 2022, and September 30, 2022, indicated for toileting needs: appropriate; which were reviews of R2's Annual Assessment dated January 8, 2022, that indicated for Bowel and Bladder; resident is incontinent of bladder; resident prefers prompted toileting and prefers use of depends.

On November 1, 2022, at 7:38 a.m. ULP-H was observed to assist R2 with toileting. ULP-H changed R2's disposable incontinent brief and wiped R2's buttocks area. ULP-H stated to R2 "you did have a little bit of BM [bowel

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01640	Continued From page 119 movement]". R2's Evaluation and Management physician note dated October 14, 2022, indicated "full incontinence of feces. Staff noting patient to have more instances of fecal incontinence. Has historically been independent in the restroom, but is requiring more cares of lately." R2's service plan/care plan lacked revision for the services of assistance with toileting/bowel incontinence and meals. On November 1, 2022, at 12:44 p.m. RN-C stated R2 required for assistance with activities of daily living (ADLs)/morning cares "more than anything cues or reminders, than assistance of one". On November 3, 2022, at 2:23 p.m. RN-C stated she was not aware of the physician note dated October 14, 2022, indicating R2 was requiring more assistance due to bowel incontinence. RN-C verified R2's service plan/care plan was not revised to include assistance with toileting due to bowel incontinence and an assessment of R2 was not completed for the change in condition related to bowel incontinence. R3 R3's service plan/careplan dated August 16, 2022, indicated R3 received services that included bathing assistance, daily lower extremity compression wrap assistance, suprapubic catheter site care and catheter bag management, skin checks, medication administration, dressing cues with some hands-on assistance, visual checks every shift, housekeeping, and laundry. Resident receives wound care and INR (international normalized ratio/lab calculation	01640		

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based on prothrombin test results; a test measuring how long it takes a blood clot to form in a blood sample) by an outside agency.

R3's diagnoses included heart failure, atrial flutter on warfarin (blood thinner to prevent blood clots), peripheral vascular disease (a condition where there is poor blood circulation to extremities), chronic kidney disease, benign prostatic hyperplasia with urinary retention and lower urinary tract symptoms (enlarged prostate causing poor bladder emptying), presence of suprapubic urinary stoma/catheter (opening to the bladder through the abdomen for urinary catheter placement), polyosteoarthitis (multiple locations of arthritis).

On November 2, 2022, at 7:00 a.m. ULP-S was observed to provide oral medications, topical cream to feet, compression wraps to both lower extremities, suprapubic catheter site care, urinary bag maintenance and exchange, light sponge bath and dressing assistance. When asked about how R3 transferred, ULP-Q replied, "he [R3] is able to self transfer now. The paperwork needs to be updated to state that."

R3's service plan dated August 16, 2022, in section labeled "Vulnerability" indicated "Resident will self propel wheelchair. All transfers will be completed with two staff and mechanical standing lift."

R3's document "documentation survey report v2" referred to as "task sheet" dated October 2022, page two, in "Mobility" indicated "transfer resdient with two staff and EZ lift."

On November 3, 2022, at approximately 4:00 p.m. RN-C stated she thought the service plan

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indicated the correct transfer information and she would need to correct the task sheet to indicate R3's ability to self transfer. RN-C identified the error in the vulnerability section.

On November 4, 2022, at 1:25 p.m. RN-C provided an updated and corrected service plan that corrected R3's ability to self transfer but could use a two person assist or a mechanical lift on an as needed basis. The service plan was signed by R3 effective November 4, 2022.

R4
R4's record lacked evidence of a service plan prior to November 1, 2022. In addition, the service plan/care plan dated November 1, 2022, lacked signatures by the facility and by the resident representative.

R4 began receiving services under the licensee's assisted living with dementia care license on August 1, 2021.

R4's service plan/careplan per facility staff dated November 1, 2022, indicated R4 received services to include medication management, weekly bathing/showering/sponge bath assistance, grooming/oral hygiene, assistance with glasses and hearing aids, dressing assistance/cues, assistance each morning and evening with TED (thromboembolic deterrent) stockings, ace wrap to lower right extremity as needed, eating encouragement, cues to use walker, safety checks (eight times per shift), toileting assistance, escort to and from dining area and activities, housekeeping, laundry and housekeeping. Additionally, R4 began receiving hospice services on August 30, 2022.

R4's diagnoses include unspecified dementia,

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psychotic disturbance (history of hallucinations), mood disturbance and anxiety, depression, age related osteoporosis (brittle/weak bones susceptible to fractures) with history of second lumbar vertebra compression fracture, asthma, dry eyes, hypertension (high blood pressure) and hypothyroidism (a condition with poor thyroid gland function).

Surveyors entered the licensee's facility on October 31, 2022, at 9:30 a.m. and requested resident records to include service plans. An unsigned and untitled service plan/care plan November 1, 2022, was provided on November 2, 2022, at 10:00 a.m.

The service plan/care plan dated November 1, 2022, lacked signatures from the licensee and by R4's designated representative.

On November 1, 2022, at 10:55 a.m. ULP-I was observed to administer an inhaler to R4.

The Licensee failed to finalize a written service plan no later than 14 calendar days after the date that services were first provided.

On November 3, 2022, at 5:00 p.m. RNS-E confirmed the date of R4's service plan to be November 1, 2022. She stated she was working with the licensee to "get everything into compliance."

On November 4, 2022, at 10:00 a.m. RN-C stated she had been in contact with R4's daughter/resident representative who would come in over the weekend to sign R4's service plan.

The licensee's 6.05 Service Plan policy dated

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01640	Continued From page 123 August 1, 2021, indicated "All residents receiving assisted living services will have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. A service plan means the written plan between a resident or residents designated representative and the facility about the services that will be provided to the resident. The procedure indicated within 14 days after the date that services are first provided to a resident [licensee name] will finalized a written service plan. The service plan and any revisions shall include a signature or other authentication by [licensee name] and by the resident, or resident's representative documenting agreement on the services to be provided. Service plans shall be revised, if needed, based on resident reassessments and monitoring." 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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01650	Continued From page 124 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 four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1	01650		

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01650	Continued From page 125 R1's diagnoses included mild cognitive impairment, Type 2 diabetes mellitus and hypertension. R1's service plan/care plan dated October 20, 2022, indicated R1 received services including assistance with pain, activities, Occupational/Physical therapy, bathing, meals, administration of medications, blood sugar checks, weights, vitals, TED hose/compression stockings (used to reduce edema) applied as ordered, assistance with ambulation long distances/stairs, fall interventions, daily room tidy, housekeeping and trash removal. In addition, the service plan identified code status of do not resuscitate (DNR). R2's contract was signed August 8, 2021, and included "Attachment F Service Plan". On November 1, 2022, at 8:36 a.m. ULP-I was observed to administer medications to R1, check R1's blood pressure, check R1's blood sugar and applied knee high TED stockings to R1's lower legs/feet. R1's service plan/care plan lacked the following: -the fees for services (all services) and the frequency of each service (bathing assistance); -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	01650		

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01650	Continued From page 126 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 145C, and declarations made by the resident under those chapters (living will). R2 R2's diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). R2's service plan/care plan dated April 15, 2022, indicated R2 received services including activities, meals, assistance with transportation/appointments/shopping, pain, cardiac, bathing, grooming/oral hygiene, dressing/undressing, medication administration, weight monitoring, vitals, assistance with ambulation long distances, housekeeping, laundry, linen changes, daily bed making, fall interventions, assistance with safety in emergency situations, skin condition and bladder/bowel; would be able to maintain bladder/bowel function without assistance; is continent of bowels; is occasionally incontinent of bladder; reminders/cues to use toilet for voiding overnight; report to nurse any changes with bladder/bowel incontinence; uses incontinence products: pull-up; supply and disposal managed by resident/family/staff; dispose of used incontinent products every shift. In addition, the service plan identified code status of DNR. On November 1, 2022, at 7:31 a.m. ULP-I was observed to administer medications to R2. At	01650		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

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01650	Continued From page 127 7:38 a.m., ULP-H was observed to assist R2 with dressing, toileting and oral cares. R2's service plan/care plan lacked the following: -a description of the services to be provided (toileting assistance, meals), the fees for services (all services) and the frequency of each service (toileting assistance, meals); -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 145C, and declarations made by the resident under those chapters (living will). On November 3, 2022, at 2:23 p.m. RN-C and regional nurse specialist (RNS)-E verified R1 and R2's service plans/care plans lacked the above content. RNS-E stated the resident's contingency plans, fees for services, the schedule and methods of monitoring assessments of the resident and the schedule and methods of monitoring staff providing services was in the residents contracts; however, R1 and R2's service plans/care plans did not reference the	01650		

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resident's contract for content required to be included in the service plan.

R3
R3's service plan/careplan dated August 16, 2022, indicated R3 received services that included bathing assistance, daily lower extremity compression wrap assistance, suprapubic catheter site care and catheter bag management, skin checks, medication administration, dressing cues with some hands-on assistance, visual checks every shift, housekeeping, and laundry. Resident receives wound care and INR (international normalized ratio/lab calculation based on prothrombin test results; a test measuring how long it takes a blood clot to form in a blood sample) by an outside agency.

R3's diagnoses included heart failure, atrial flutter on warfarin (blood thinner to prevent blood clots), peripheral vascular disease (a condition where there is poor blood circulation to extremities), chronic kidney disease, benign prostatic hyperplasia with urinary retention and lower urinary tract symptoms (enlarged prostate causing poor bladder emptying), presence of suprapubic urinary stoma/catheter (opening to the bladder through the abdomen for urinary catheter placement), polyosteoarthitis (multiple locations of arthritis).

R3's Service plan/care plan lacked the following:
- the fees for services (all 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;

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01650	Continued From page 129 (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 145C, and declarations made by the resident under those chapters (living will). On November 1, 2022, at 12:44 p.m. RNS-E stated the resident's contingency plans, fees for services, the schedule and methods of monitoring assessments of the resident and the schedule and methods of monitoring staff providing services was in the residents contracts; however, R3's service plan/care plan did not reference the resident's contract for content required to be included in the service plan. R4 R4 began receiving services under the licensee's assisted living facility with dementia care license on August 1, 2021. R4's service plan/careplan dated November 1, 2022, indicated R4 received services to include medication management, weekly bathing/showering/sponge bath assistance, grooming/oral hygiene, assistance with glasses and hearing aids, dressing assistance/cues, assistance each morning and evening with TED (thromboembolic deterrent) stockings, ace wrap to lower right extremity as needed, eating encouragement, cues to use walker, safety	01650		

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checks (eight times per shift), toileting assistance, escort to and from dining area and activities, housekeeping, laundry and housekeeping. Additionally, R4 began receiving hospice services on August 30, 2022.

On November 1, 2022, at 10:55 a.m. ULP-I was observed to administer an inhaler to R4.

R4's record lacked an assisted living with dementia care contract that contained the following required elements of the service plan:
-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:
- the action to be taken if the scheduled service cannot be provided;
-information and a method to contact the facility;
- 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
- 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 November 3, 2022, at 3:25 p.m. RNS-E stated the requirements listed are found in the licensee's contract. RNS-E confirmed the licensee failed to ensure R4 had a contract in place and stated "I am working with the licensee to get everything into compliance."

The licensee's 6.05 Service Plan policy dated

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01650	Continued From page 131 August 1, 2021, indicated the resident service plans would include the required content according to 144G.70 Subd. 4. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01710 SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure reassessment of medication management services at a minimum annually included all required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01710		

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01710	Continued From page 132 The findings include: R1 R1's diagnoses included mild cognitive impairment (memory loss), Type 2 diabetes mellitus (too much sugar in the blood) and hypertension (high blood pressure). R1's service plan/care plan dated October 20, 2022, indicated R1 received services including administration of medications. On November 1, 2022, at 8:36 a.m. unlicensed personnel (ULP)-I was observed to administer medications to R1. R1's Medication Administration Record (MAR) dated October 2022, indicated staff were administering two medications used to remove wax from ears, five used for pain, one used for heart condition, three used for supplement, two used for allergies, one used for depression, two used to treat high cholesterol, three used to treat diabetes, one used to treat high blood pressure, two used for constipation, one used to treat anemia (a condition in which the blood does not make enough healthy red blood cells), one used to prevent blood clots, one used for acid reflux and one used for cough and congestion. The MAR included indications for the medications. R1's Medication/Treatment/Therapy Assessment and Plan dated October 20, 2022, indicated the assessment was conducted "face to face" and included "staff administer medications" and "see MAR/TAR [medication administration record/treatment administration record] and/or medication/treatment assessment and plan for resident specific information. Medication/treatment/therapy will be monitored by	01710		

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the licensed nurse to prevent possible complications or adverse reactions" and "concerns about potentially inappropriate medications/contraindications/side effects with medications you are currently taking (reviewed all current medications prescribes as of this assessment date: N/A [not applicable]."

R1's medication reassessment lacked documented evidence of the following required content:
-identification and review of side effects
-review of contraindications, allergic or adverse reactions, and actions to address these issues

R2
R2's diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions).

R2's service plan/care plan dated April 15, 2022, indicated R2 received services including administration of medications.

On November 1, 2022, at 7:31 a.m. ULP-I was observed to administer medications to R2.

R2's MAR dated October 2022, indicated staff were administering three medications for Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), one used for heart condition, one used for depression, one used for bone density (the amount of bone mineral in bone tissue) and one used for pain. The MAR included indications for the medications.

R2's Medication/Treatment/Therapy Assessment and Plan dated September 30, 2022, indicated the assessment was conducted "face to face"

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and included "staff administer medications" and "see MAR/TAR [medication administration record/treatment administration record] and or medication/treatment assessment and plan for resident specific information. Medication/treatment/therapy will be monitored by the licensed nurse to prevent possible complications or adverse reactions" and "concerns about potentially inappropriate medications/contraindications/side effects with medications you are currently taking (reviewed all current medications prescribes as of this assessment date: none at this time."

R2's medication reassessment lacked documented evidence of the following required content:
-identification of side effects

On November 3, 2022, 2:23 p.m. registered nurse (RN)-C and regional nurse specialist (RNS)-E verified R1 and R2's Medication/Treatment/Therapy Assessment and Plans lacked the above content. RN-C stated, "We load medications" (information about medications) into the licensee computer system. RN-C and RNS-E verified the side effects of medications residents were being administered were not listed on the resident's MARs or medication assessment and plan.

R3
R3's service plan/careplan dated August 16, 2022, indicated R3 received services that included medication administration.

R3's diagnoses included heart failure, atrial flutter on warfarin (blood thinner to prevent blood clots), peripheral vascular disease (a condition where there is poor blood circulation to extremities),

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chronic kidney disease, benign prostatic hyperplasia with urinary retention and lower urinary tract symptoms (enlarged prostate causing poor bladder emptying), presence of suprapubic urinary stoma/catheter (opening to the bladder through the abdomen for urinary catheter placement), polyosteoarthitis (multiple locations of arthritis).

R3's MAR dated October 2022, indicated R3 received medications that included one medication for heart failure, one for sleep, one supplement, one blood thinner, one for bowel, three ointments/creams for skin, two for constipation, two eye medications and one mild pain medication.

On November 2, 2022, at 7:00 a.m. ULP-S was observed to provide oral medications.

R4
R4's service plan/careplan dated November 1, 2022, indicated R4 received services to include medication management.

R4's diagnoses include unspecified dementia, psychotic disturbance (history of hallucinations), mood disturbance and anxiety, depression, age related osteoporosis (brittle/weak bones susceptible to fractures) with history of second lumbar vertebra compression fracture, asthma, dry eyes, hypertension (high blood pressure) and hypothyroidism (a condition with poor thyroid gland function).

R4's medications include one for depression, one for hallucinations/agitation, one for anxiety, one for sleep, one for hypothyroidism (a condition with poor thyroid gland function), two for asthma, one for itching skin, four for pain, and one nutritional

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01710	Continued From page 136 supplement drink, one for constipation, one cream for dry skin, one for excessive secretions, and one for nausea. On November 1, 2022, at 10:55 a.m. ULP-I was observed to administer an inhaler to R4. R3 and R4's records lacked evidence the RN conducted a review of all medications the residents were known to be taking to include a review of the side effects and contraindications. On November 3, 2022, at 5:10 p.m. RN-C stated the review of side effects should be within the assessment and confirmed it was not included, nor completed. The licensee's Medication Management Assessment, Monitoring and Reassessment policy dated August 1, 2021, indicated "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". No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01710		
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	01730		

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01730	Continued From page 137 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 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	01730		

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review, the licensee failed to ensure an individualized medication management plan included all required content for four of four residents (R1, R2, R3, R4).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R1
R1's diagnoses included mild cognitive impairment (memory loss), Type 2 diabetes mellitus (too much sugar in the blood) and hypertension (high blood pressure).

R1's service plan/care plan dated October 20, 2022, indicated R1 received services including administration of medications and vulnerability of "anxiety/depression/mental illness vulnerability interventions are: resident has a diagnoses of depression. Staff to administer medication as prescribed and update nurse of changes in mood of cognition."

On November 1, 2022, at 8:36 a.m. unlicensed personnel (ULP)-I was observed to administer medications to R1.

R1's Medication/Treatment/Therapy Assessment and Plan dated October 20, 2022, indicated "staff administer medications" and "see MAR/TAR

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01730	Continued From page 139 [medication administration record/treatment administration record] and or medication/treatment assessment and plan for resident specific information. Staff will notify the licensed nurse or appropriate licensed health professional when a problem arises with a medication/treatment/therapy service. For specific instructions and frequency or services refer to PCP [primary care provider] orders, or see EMAR [electronic medication administration record]/Tasks. The services to be provided will be documented in detail on the ISP [individual service plan] and/or EMAR. This shall serve as the medication/treatment/therapy assessment and plan." R1's Medication Administration Record (MAR) dated October 2022, indicated staff were administering two medications used to remove wax from ears, five used for pain, one used for heart condition, three used for supplement, two used for allergies, one used for depression, two used to treat high cholesterol, three used to treat diabetes, one used to treat high blood pressure, two used for constipation, one used to treat anemia (a condition in which the blood does not make enough healthy red blood cells), one used to prevent blood clots, one used for acid reflux and one used for cough and congestion. R1's record/Medication/Treatment/Therapy Assessment and Plan/EMAR/PCP orders/ISP lacked specific instructions for parameters for which as needed (PRN) medication to use first for ear wax removal (carbamide peroxide or mineral oil); lacked parameters for which PRN medication to use first for pain (oxycodone or lidocaine patch); lacked clear direction of parameters for blood pressure (BP) (did not identify systolic (top number) or diastolic (bottom number)/two	01730		

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01730	Continued From page 140 numbers used to measure blood pressure) related to direction of "inform nurse if BP is 100<[greater] >[less]70"; and lacked identified specific behaviors/symptoms and monitoring of the behavioral symptoms to determine effectiveness of the medication for the use of citalopram (used to treat depression)medication. R1's individualized medication management record lacked the following: -documentation of specific resident instructions relating to the administration of medications On November 3, 2022, 2:23 p.m. registered nurse (RN)-C and regional nurse specialist (RNS)-E verified R1's record lacked the above. RN-C stated regarding BP parameters "that's confusing for sure". RN-C stated the ULP does not have to call the nurse for "all PRN" medication administration. Monitoring of the behavioral symptoms to determine effectiveness of the medication for the use of citalopram medication was requested; however, no information was provided. R2 R2's diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). R2's service plan/care plan dated April 15, 2022, indicated R2 received services including administration of medications and vulnerability of "anxiety/depression/mental illness vulnerability interventions are: resident has diagnoses of Alzheimer's dementia and depressive disorder. Has periods of increased confusion and anxiety. Medications are administered per prescriber's orders and monitored for efficacy. Staff provide visits when change in baseline is noted."	01730		

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01730	Continued From page 141 On November 1, 2022, at 7:31 a.m. ULP-I was observed to administer medications to R2. R2's Medication/Treatment/Therapy Assessment and Plan dated September 30, 2022, indicated "staff administer medications" and "see MAR/TAR [medication administration record/treatment administration record] and or medication/treatment assessment and plan for resident specific information. For specific instructions and frequency or services refer to PCP [primary care provider] orders, or see EMAR [electronic medication administration record]/Tasks. The services to be provided will be documented in detail on the ISP [individual service plan] and/or EMAR. This shall serve as the medication/treatment/therapy assessment and plan." R2's MAR dated October 2022, indicated staff were administering three medications for Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), one used for heart condition, one used for depression, one used for bone density (the amount of bone mineral in bone tissue) and one used for pain. R2's record/Medication/Treatment/Therapy Assessment and Plan/EMAR/PCP orders/ISP lacked identified specific behaviors/symptoms and monitoring of the behavioral symptoms to determine effectiveness of the medication for the use of escitalopram (used to treat depression/anxiety) and risperidone (an antipsychotic medication used to treat schizophrenia/bipolar disorder) medications. R2's individualized medication management	01730		

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01730	Continued From page 142 record lacked the following: -documentation of specific resident instructions relating to the administration of medications On November 3, 2022, 2:23 p.m. RN-C and RNS-E verified R2 record lacked the above. Monitoring of the behavioral symptoms to determine effectiveness of the medication for the use of escitalopram and risperidone medication was requested; however, no information was provided. R3 R3's record lacked specific instruction for bleeding and bruising with use of warfarin. R3's service plan/careplan dated August 16, 2022, indicated R3 received services that included medication administration. Resident received wound care and INR (international normalized ratio/lab calculation based on prothrombin test results; a test measuring how long it takes a blood clot to form in a blood sample) by an outside agency. R3's diagnoses included heart failure, atrial flutter on warfarin (blood thinner to prevent blood clots), peripheral vascular disease (a condition where there is poor blood circulation to extremities), chronic kidney disease, benign prostatic hyperplasia with urinary retention and lower urinary tract symptoms (enlarged prostate causing poor bladder emptying), presence of suprapubic urinary stoma/catheter (opening to the bladder through the abdomen for urinary catheter placement), polyosteoarthitis (multiple locations of arthritis). R3's Medication Record (MAR) dated October	01730		

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01730	Continued From page 143 2022, indicated staff were administering medications that included one medication for heart failure, one for sleep, one supplement, one blood thinner, one for bowel, three ointments/creams for skin, two for constipation, two eye medications and one mild pain medication. On November 2, 2022, at 7:00 a.m. ULP-S was observed to provide oral medications and topical cream to feet. R3's document labeled MN (licensee name) Medication/Treatment/Therapy Assessment and Plan dated October 5, 2022, under 23. Intervention: "See MAR/TAR and/or medication/treatment assessment and plan for resident specific information. R3's MAR dated October 2022, indicated "Warfarin Sodium tablet, Give 2.5 milligram (mg) by mouth at bedtime related to atypical atrial flutter." R3's record lacked specific instructions to monitor R3 for bleeding or bruising related to the administration of warfarin. On November 3, 2022, at 4:10 p.m. RN-C and RNS-E indicated the practice was for the RN to complete a medication/treatment assessment and plan revision with each resident 90 day or change in condition assessment. RN-C confirmed there were no specific instructions to monitor for bleeding or bruising in R3's medication plan nor R3's MAR. RN-C identified the concerns ULP would need to know with warfarin, being bleeding and bruising and would "need to look closer to be sure to include this information."	01730		

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R4
R4's medication plan was not updated with R4's hospice enrollment (change in condition) on August, 30, 2022, and lacked instruction for R4's as needed (PRN) medications as prescribed by R4's hospice provider.

R4's service plan/careplan dated November 1, 2022, indicated R4 received services to include medication management.

R4's diagnoses include unspecified dementia, psychotic disturbance (history of hallucinations), mood disturbance and anxiety, depression, age related osteoporosis (brittle/weak bones susceptible to fractures) with history of second lumbar vertebra compression fracture, asthma, dry eyes, hypertension (high blood pressure) and hypothyroidism (a condition with poor thyroid gland function).

R4's MAR dated October 2022, indicated medications staff were administering to include one for depression, one for hallucinations/agitation, one for anxiety, one for sleep, one for hypothyroidism (a condition with poor thyroid gland function), two for asthma, one for itching skin, four for pain, and one nutritional supplement drink, one for constipation, one cream for dry skin, one for excessive secretions, and one for nausea.

On November 1, 2022, at 10:55 a.m. ULP-I was observed to administer an inhaler to R4.

R4 began receiving hospice services on August 30, 2022.

R4's hospice provider orders dated August 30, 2022 included:

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01730	Continued From page 145 -acetaminophen suppository 650 mg, one suppository rectally every six hours as needed for mild pain/fever -lorazepam tablet 0.5 mg, one tablet every four hours as needed for anxiety -morphine sulfate 2.5 mg, one tablet under the tongue every one hour as needed for pain or shortness of breath. -quetiapine 25 mg, give 0.5 tablet every evening at bedtime for agitation/delirium -quetiapine 25 mg, give 0.5 tablet once daily as needed for agitation/delirium R4's MN Comprehensive-V2 Assessment dated September 22, 2022, lacked a medication/treatment assessment and plan revision. R4's service plan/care plan dated November 1, 2022, in section Medications, indicated "See MAR/TAR and/or medication treatment assessment and plan for resident specific information." There were no clear directions to the ULP for which as needed pain medication (acetaminophen or morphine sulfate) should be used when R4 indicated pain, or symptoms of pain for which the ULP would need to contact a nurse. In addition, there were no instructions for the ULP to contact nursing for use of the as needed lorazepam or quetiapine. R4's record lacked alternate non-pharmacological means for ULP to manage R4's anxiety. On November 3, 2022, at 4:10 p.m. RN-C and RNS-E indicated the practice was for the RN to complete a medication/treatment assessment and plan revision with each resident 90 day or change in condition assessment. RN-C confirmed	01730		

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01730	Continued From page 146 R4's record lacked the medication assessment with the comprehensive assessment completed on September 22, 2022, and confirmed the lack of specific direct for ULP to call nursing for the indicated as needed medications. The licensee's Medication and Treatments Administration and Delegation policy dated August 1, 2021, indicated when administration of medications was delegated or assigned to unlicensed personnel, the license would ensure that the RN had specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. The license's ALDC (assisted living dementia care) Behavioral Symptoms, Interventions and Nonpharmacological Approaches policy dated August 1, 2021, indicated the licensee supports person-centered and evidence based evaluation of behavioral symptoms and design of supports for intervention plans; including nonpharmacological interventions or practices in the following ways: would identify behavioral symptoms that negatively impact other residents and others in an assisted living facility and evaluate to determine potential interventions to minimize such behaviors. Interventions would be identified on the care plan or service plan. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility	01750		

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must ensure that the registered nurse has:
(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;
(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and
(3) communicated with the unlicensed personnel about the individual needs of the resident.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure medication was administered as ordered for one of four 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:

R1's diagnoses included mild cognitive impairment (memory loss), Type 2 diabetes mellitus (too much sugar in the blood) and hypertension (high blood pressure).

R1's service plan/care plan dated October 20, 2022, indicated R1 received services including administration of medications.

On November 1, 2022, at 8:36 a.m. unlicensed

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personnel (ULP)-I was observed to administer medications to R1. ULP-I was observed to place a glass with Miralax (used for constipation) medication mixed in water next to R1 who was seated in a chair. ULP-I administered oral (tablet) medications to R1, checked R1's blood pressure by utilizing an automatic blood pressure cuff, checked R1's blood sugar, applied TED [thromboembolic deterrent] (used to reduce edema) stockings to R1's lower legs/feet and walked out of R1's apartment. The glass of Miralax remained undrank by R1. ULP-I did not ensure R1 drank the Miralax medication before leaving R1's apartment.

R1's Medication/Treatment/Therapy Assessment and Plan dated October 20, 2022, indicated R1 "needs assistance" for medication administration services and "problem areas: takes medication inappropriately (e.g. misses doses, takes excessive amounts, or misplaces medications), dexterity" and intervention of "staff administer medications".

On November 1, 2022, 12:44 p.m. registered nurse (RN)-C stated regarding Miralax medication being left in R1's room unattended and ULP-I not ensuring R1 drank the medication, "I think she would be okay, as cognitively intact and drinks it". RN-C stated the process for a resident to self-administer medications was to "get an order from the nurse practitioner to self-administer and put on the MAR can self administer" the medication. RN-C self-administration of medication would be addressed in the assessment. Regional nurse specialist (RNS)-E verified R1's record/assessment did not address R1's ability to self-administer the Miralax.

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01750	Continued From page 149 The licensee's Medication and Treatments Administration and Delegation policy dated August 1, 2021, indicated when administration of medications was delegated or assigned to unlicensed personnel the license would ensure that the RN had specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. RN would instruct the ULP on medication administration prior to delegating the task to the ULP the administration of the medication to the resident. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01750		
01790 SS=D	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	01790		

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01790	Continued From page 150 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 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.	01790		

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01790	Continued From page 151 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations for preparing medications for resident unplanned times away were completed as required for one of six unlicensed personnel (ULP-J). 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-J had a hire date of March 1, 2022. ULP-J provided direct care and services to residents, including medication administration. ULP-J's record 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 November 4, 2022, at 11:49 a.m. RN-C and RNS-E verified ULP-J's record lacked documented evidence of training and demonstrated competency to prepare and administer medications to residents for unplanned times away. RN-C verified the ULP provided the above delegated task for resident	01790		

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01790	Continued From page 152 services. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations must be conducted by an RN and only unlicensed personnel who were determined competent and posses the knowledge and skills consistent with the complexity of tasks being delegated would be permitted to perform such tasks. The assisted living would have a system in place to communicate up to date information to a RN regarding current available staff and their competencies. The licensee's Medication and Treatment Administration and Delegation policy dated August 1, 2022, indicated ordered or prescribed medication may be administered by unlicensed personnel who have been delegated medication administration tasks by a registered nurse. Prior to providing administration of medications the RN must instruct the ULP on medication administration task before delegating the task to them and the ULP must demonstrate their ability to competently follow the delegated medication administration to the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
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	01880		

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01880	Continued From page 153 permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On October 31, 2022, during entrance conference at approximately 10:00 a.m. registered nurse (RN)-C reviewed the locations of the facility's medication carts and storage. RN-C stated there was a mini-refrigerator in the locked staff room in the memory care unit. Medications requiring refrigeration for all facility residents were kept in this mini-refrigerator. On November 1, 2022, at 11:10 a.m. the surveyor and unlicensed personnel (ULP)-I completed a review of the contents and temperature of the mini-refrigerator where medications were stored. The surveyor observed a thermometer hanging below the first shelf of the refrigerator with a temperature reading of 30 degrees Fahrenheit (F). ULP-I confirmed the thermometer temperature at that time. ULP-I stated she	01880		

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01880	Continued From page 154	01880		

believed the late night staff completed a nightly temperature check of the mini-refrigerator but was unable to locate a temperature log. ULP-I stated licensed practical nurse (LPN)-R often monitored the temperature log.

Contents of the mini-refrigerator included:
-lantus solostar (insulin) - one pen (package recommended storage temperature prior to first use 36-46 degrees F.)
-Trulicity (insulin) - one pen (package read recommended storage temperature 36-46 degrees F.)
-lantus solostar (insulin) - four pens (package recommended storage temperature prior to first use 36-46 degrees F.)
-Repatha sure click injection (to reduce bad cholesterol) - one pen (package read recommended storage temperature 36-46 degrees F.)
-Tubersol solution (for staff tuberculosis testing) - three bottles (package insert dated 2016, read store between 35-46 degrees F.)

On November 1, 2022, at 12:45 p.m.. RN-C and regional nurse specialist (RNS)-E stated there was a recent update to the refrigerator temperature log sheet that were being developed. RN-C stated she thought the mini-refrigerator temperature was checked by the overnight staff but referred to LPN-R about her process for review. RNS-E stated the licensee would follow up on the insulin and Tubersol that were stored below recommended temperatures.

On November 1, 2022, at 2:00 p.m. LPN-R stated she had not been reviewing the temperature logs and understood the staff were to be checking the mini-refrigerator on a daily basis. LPN-R stated she was far behind in her tasks and had failed to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 155 follow up with mini-refrigerator temperature log review. The licensee's Medication and Treatments policy (7.08) dated August 1, 2021, read "When medications are managed and stored by [licensee], medications will be kept securely locked and stored per manufacturer's directions. Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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	01940		

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01940	Continued From page 156	01940		

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 treatment plan included all required content for three of three residents (R1, R3, R4).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 mild cognitive impairment (memory loss), Type 2 diabetes mellitus (too much sugar in the blood) and hypertension (high blood pressure).

On November 1, 2022, at 8:36 a.m. unlicensed personnel (ULP)-I was observed to check R1's

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01940	Continued From page 157 blood sugar (a test used to estimate level of sugar in blood) and applied knee high TED [thromboembolic deterrent] stockings (used to reduce swelling) to R1's lower legs/feet. R1's Order Summary Report dated October 28, 2022, included an order for True Metrix (brand name) blood glucose strip "(glucose blood)" one strip in vitro (outside the body) two times a day related to Type 2 diabetes mellitus without complications. The Order Summary Report lacked a prescriber order for TEDs. R1's Medication/Treatment/Therapy Assessment and Plan dated October 20, 2022, included "Blood glucose checks done "at" [as] prescribed. See MAR [medication administration record]/TAR [treatment administration record]/Tasks, TED hose/compression stockings applied as ordered. See MAR/TAR/Tasks" and "Staff will notify the licensed nurse or appropriate licensed health professional when a problem arises with a medication/treatment/therapy service. For specific instructions and frequency or services refer to PCP [primary care provider] orders, or see EMAR [electronic medication administration record]/Tasks. The services to be provided will be documented in detail on the ISP [individual service plan] and/or EMAR. This shall serve as the medication/treatment/therapy assessment and plan." R1's service plan/care plan dated October 20, 2022, indicated R1 received services including "treatment/Therapies" which included blood glucose checks done as prescribed. See MAR/TAR/Tasks. TED hose/compression stockings applied as ordered. See MAR/TAR/Tasks. See MAR/TAR and/or medication/treatment assessment and plan for	01940		

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01940	Continued From page 158 resident specific information. R1's MAR dated October 2022, included "True Metrix [brand name] blood glucose strip (glucose blood) 1 strip in vitro [outside the body] two times a day related to Type 2 diabetes mellitus without complications". The MAR lacked documented information for TEDs. R1's Documentation Survey Report (tasks sheets) dated October 2022, lacked documented information for blood glucose checks and TEDs. R1's record/Medication/Treatment/Therapy Assessment and Plan/EMAR/PCP orders/ISP lacked specific instructions for parameters for blood sugar checks (high/low readings) and for TEDs (knee high or thigh high) and lacked procedures for notifying a registered nurse when a problem arises with treatments as indicated on R1's Medication/Treatment/Therapy Assessment and Plan above. R1's individualized treatment/therapy record lacked the following: -documentation of specific resident instructions relating to the treatments or therapy administration; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services On November 3, 2022, 2:23 p.m. registered nurse (RN)-C and regional nurse specialist (RNS)-E verified R1 record lacked the above. RN-C stated regarding specific instructions for blood sugar check, "no we don't have specific instructions. If above 350 staff notify the nurse".	01940		

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01940	Continued From page 159 R3 R3's diagnoses included heart failure, atrial flutter on warfarin (blood thinner to prevent blood clots), peripheral vascular disease (a condition where there is poor blood circulation to extremities), chronic kidney disease, benign prostatic hyperplasia with urinary retention and lower urinary tract symptoms (enlarged prostate causing poor bladder emptying), presence of suprapubic urinary stoma/catheter (opening to the bladder through the abdomen for urinary catheter placement), polyosteoarthitis (multiple locations of arthritis). R3's service plan/care plan dated August 16, 2022, indicated R3 received services that included daily lower extremity compression wrap assistance, suprapubic catheter site care and catheter bag management. Resident receives wound care and INR (international normalized ratio/lab calculation based on prothrombin test results; a test measuring how long it takes a blood clot to form in a blood sample) by an outside agency. On November 2, 2022, at 7:00 a.m. ULP-S was observed to provide compression wraps to both lower extremities, suprapubic catheter site care, urinary bag maintenance and exchange, Surveyor observed a small hydrocolloid dressing on left outer foot dated November 1, 2022. ULP-S stated "The home health agency manages the dressing, there's an area on the side of his [R3] foot they are trying to soften, kind of like a callus or something. His other wounds have healed and they are working with just this one now." When surveyor asked what the ULP role was with the hydrocolloid dressing, ULP-S stated, "We just make sure it's there and if it's not there's a corn	01940		

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01940	Continued From page 160 pad in his cupboard we put on. The home health nurse comes and takes care of it otherwise." R3's record included home health agency nurse notes dated from May 4, 2022, through October 20, 2022, indicated they managed R3's wound care for several lower extremity wounds. By October 2022, previously treated wounds on heels and toes had healed and the only area the home health agency was managing was a callused area on the left outer foot requiring a hydrocolloid dressing. R3's record included home health agency notes from the home health nurse regarding direction and concerns with the hydrocolloid dressing not being in place with several visits. Home health agency Care Communication note dated September 28, 2022, by home health licensed practical nurse read "New hydrocolloid dressing applied to left foot, dressing is to remain in place for 7 (seven) days. I re-wrapped his legs also. ***PLEASE tell your staff to leave the dressing on his left foot. For the past three (3) weeks when we have come it has been off and either open to the air or has a corn pad on it. The hydrocolloid dressing is to remain on for 7 (seven) days, I wrote on the dressing to not remove it. Recommendations: Leave dressing in place or if it comes off, replace with a new one. Dressings are in a box in his room." R3's Service plan/care plan dated August 16, 2022, in section Treatments/Therapies interventions indicated "Catheter care done as ordered/requested, See MAR/TAR/TASKS. Juxta wraps (compression wraps) to lower extremities done as ordered, See MAR/TAR/TASKS. See MAR/TAR and/or medication/treatment assessment and plan for resident specific	01940		

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01940	Continued From page 161 information." R3's Service plan/care plan dated August 16, 2022, in section Skin Condition indicated "Chronic skin conditions/scars: Ulcers on feet. Wound care is managed by [home health agency name] and [clinic name] wound clinic. Special skin issues-Interventions are: stoma care, nystatin powder to groin area for irritation." R3's document labeled "Documentation Survey Report v2" dated October 2022, known as the "task documentation record", on page two indicated a start date of October 5, 2022, for each shift (day, evening, night), "Hydrocolloid dressing to left foot." The record did not include clear or specific instruction for this task or for what ULP needed to do if dressing was not in place. R3's task documentation record dated October 2022, also included compression wraps with the instructions "compression wraps to be applied to both legs and feet with morning dressing. Put on slipper socks over the compression wraps. Compression wraps to be removed when resident prepares for bed." With a known history of lower extremity wounds, the licensee failed to provide written instructions for ULP to monitor and report any concerns with redness, skin breakdown or other concerns associated with the compression wraps. On November 3, 2022, at 5:00 p.m. registered nurse (RN)-C stated the home health agency nurses managed R3's wound care about three times each week. RN-C stated " I often made visits with the home health nurse to see R3's wounds, but I did not always document these	01940		

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01940	Continued From page 162 visits. The recommendations from the home health nurse were entered into the "dashboard" for ULP to see. The leadership team provided daily summaries for the residents but delete after seven days." RN-C confirmed the entry in the task record was unclear and lacked specific directions for ULP to follow if the dressing was not in place. RN-C verified R3's record lacked clear instruction for ULP to reference regarding his compression wraps. R4 R4's record lacked written instructions for TED (thromboembolic deterrent) stockings/Ace wraps monitoring. R4's service plan/care plan per facility staff dated November 1, 2022, indicated R4 received services to include assistance each morning and evening with TED stockings, and ace wrap to lower right extremity as needed. Additionally, R4 began receiving hospice services on August 30, 2022. R4's diagnoses included unspecified dementia, psychotic disturbance (history of hallucinations), mood disturbance and anxiety, depression, age related osteoporosis (brittle/weak bones susceptible to fractures) with history of second lumbar vertebra compression fracture, asthma, dry eyes, hypertension (high blood pressure) and hypothyroidism (a condition with poor thyroid gland function). On November 1, 2022, at 10:55 a.m. the surveyor observed R4 was not wearing TED stockings. ULP-I stated R4 often refused them or removed them herself.	01940		

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01940	Continued From page 163 R4's service plan/care plan dated November 1, 2022, page five in section, Dressing intervention indicated, "Prefers assistance with putting on TEDS in the a.m. and removing TEDS in the p.m. as needed and as ordered by PCP [primary care provider]." Additionally, page nine in section Treatment intervention, indicated "TED hose/compression stockings applied as ordered. See MAR/TAR/TASKS as needed for edema." In R4's service plan/care plan in section of Skin Condition the intervention read, "Special skin issues. Interventions are: Staff assist weekly with shower and report any concerns to nursing." In the service plan/care plan in section of Treatments/Therapies the interventions/tasks read "See MAR/TAR and/or medication treatment assessment and plan for resident specific information. TED hose/compression stockings applied as ordered, See MAR/TAR/Tasks as needed for edema." R4's Documentation Survey Report v2 dated October 2022, indicated for day shift and evening shift "Compression Stockings- Put on and off and wash out." This same record indicated as needed (PRN) use of an ace wrap to lower right extremity. Figure 8 beginning at toes up to knee. Apply tubigrips beneath wrap, on in a.m. off at p.m." R4's record lacked specific instruction for ULP to monitor regarding specific instruction for applying TED stockings and the Ace wrap to right lower extremity and when to report concerns to nursing. On November 3, 2022, at 5:00 p.m. RN-C verified lack of direction and clear instruction for use of the TED stockings and Ace wrap. The licensee's Treatment and Therapy	01940		

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01940	Continued From page 164 Management Plan policy dated August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain the required content in reference to 144G.72 Subd. 3. No further information was provided. TIME PERIOD TO CORRECT- 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 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	01950		

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01950	Continued From page 165 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 three of three residents (R1, R3, R4); and had instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident and two of six unlicensed personnel (ULP-M, ULP-P) 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 R1's Medication/Treatment/Therapy Assessment and Plan dated October 20, 2022, included "Blood glucose checks done "at" [as] prescribed. See MAR [medication administration record]/TAR [treatment administration record]/Tasks, TED [thromboembolic deterrent] hose/compression stockings applied as ordered. See MAR/TAR/Tasks" and "Staff will notify the licensed nurse or appropriate licensed health professional when a problem arises with a medication/treatment/therapy service. For specific instructions and frequency or services refer to PCP [primary care provider] orders, or see EMAR [electronic medication administration record]/Tasks. The services to be provided will be	01950		

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01950	Continued From page 166	01950		

documented in detail on the ISP [individual service plan] and/or EMAR. This shall serve as the medication/treatment/therapy assessment and plan."

R1's service plan/care plan dated October 20, 2022, indicated R1 received services including "treatment/Therapies" which included blood glucose checks done as prescribed. See MAR/TAR/Tasks. TED hose/compression stockings applied as ordered. See MAR/TAR/Tasks. See MAR/TAR and/or medication/treatment assessment and plan for resident specific information.

On November 1, 2022, at 8:36 a.m. unlicensed personnel (ULP)-I was observed to check R1's blood sugar (a test used to estimate level of sugar in blood) and applied knee high TED stockings (used to reduce swelling) to R1's lower legs/feet.

R1's MAR dated October 2022, included "True Metrix [brand name] blood glucose strip (glucose blood) 1 strip in vitro [outside the body] two times a day related to Type 2 diabetes mellitus without complications". The MAR lacked documented information for TEDs.

R1's Documentation Survey Report (tasks sheets) dated October 2022, lacked documented information for blood glucose checks and TED's.

R1's record/Medication/Treatment/Therapy Assessment and Plan/EMAR/PCP orders/ISP lacked specific instructions for parameters for blood sugar checks (high/low readings) and for TEDs (knee high or thigh high).

On November 3, 2022, at 2:23 p.m. registered

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01950	Continued From page 167 nurse (RN)-C and regional nurse specialist (RNS)-E verified R1 record lacked specific instructions for delegated treatment tasks of blood sugar checks and TEDs. RN-C stated regarding specific instructions for blood sugar check, "no we don't have specific instructions. If above 350 staff notify the nurse". ULP TRAINING AND DEMONSTRATED COMPETENCY During the entrance conference on October 31, 2022, at 9:58 a.m. RN-C confirmed the licensee utilized staff from supplemental staffing agencies to maintain staffing for the facility. The licensee staff schedule provided by RN-C identified ULP-M (staff from supplemental staffing agency) was working on the floor providing direct care and services to residents on Monday October 31, 2022, for the "a.m. shift". On November 3, 2022, at 10:00 a.m. ULP-P (staff from supplemental staffing agency) and ULP-O were observed to transfer a resident by use of an EZ stand (mechanical lift). ULP-M stated it was the first day of working in the facility and prior to working on the floor with residents she had "10 minutes of orientation by a night shift resident assistant" (RA). ULP-P stated it was the first day of working in the facility and prior to working on the floor with residents "two night shift RA's talked through residents and I took notes." ULP-P stated the staffing agency he worked for "does no training about the facility, except where to park and what door to come in." ULP-P stated he had assisted residents this a.m. with applying "TEDs, Ace wraps [used to reduce swelling], a plastic leg brace to keep foot from turning and changed a catheter bag to a leg bag".	01950		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

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01950	Continued From page 168 ULP-M and ULP-P's records lacked documented evidence the licensee had trained and determined ULP-M and ULP-P was competent to administer the treatment service of TEDs, Ace wraps, leg brace and changing catheter drainage bag to catheter leg bag. On November 4, 2022, at 11:49 a.m. RN-C and RNS-E verified ULP-M and ULP-P's records lacked documented evidence of training and demonstrated competency for the above treatment services. RN-C verified the ULP provided the above delegated treatments for resident services. RN-C verified she had not provided any training and competency to ULP-M and ULP-P for delegated treatments. R3 The licensee failed to provide instructions for the ULP to reference for wound care/dressing monitoring and monitoring skin condition with compression wraps to both lower extremities. R3's service plan/care plan dated August 16, 2022, indicated R3 received services that included daily lower extremity compression wrap assistance, suprapubic catheter site care and catheter bag management. Resident receives wound care and INR (international normalized ratio/lab calculation based on prothrombin test results; a test measuring how long it takes a blood clot to form in a blood sample) by an outside agency. R3's diagnoses included heart failure, atrial flutter on warfarin (blood thinner to prevent blood clots), peripheral vascular disease (a condition where there is poor blood circulation to extremities),	01950		

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chronic kidney disease, benign prostatic hyperplasia with urinary retention and lower urinary tract symptoms (enlarged prostate causing poor bladder emptying), presence of suprapubic urinary stoma/catheter (opening to the bladder through the abdomen for urinary catheter placement), polyosteoarthitis (multiple locations of arthritis).

On November 2, 2022, at 7:00 a.m. ULP-S was observed to provide compression wraps to both lower extremities, suprapubic catheter site care, urinary bag maintenance and exchange. The surveyor observed a small hydrocolloid dressing on left outer foot dated November 1, 2022. ULP-Q stated "The home health agency manages the dressing, there's an area on the side of his [R3] foot they are trying to soften, kind of like a callus or something. His other wounds have healed and they are working with just this one now." When surveyor asked what the ULP role was with the hydrocolloid dressing, ULP-Q stated, "We just make sure it's there and if it's not, there's a corn pad in his cupboard we put on. The home health nurse comes and takes care of it otherwise."

R3's record included home health agency nurse notes dated from May 4, 2022, through October 20, 2022, indicating they managed R3's wound care for several lower extremity wounds. By October 2022, previously treated wounds on heels and toes had healed and the only area the home health agency was managing, was a callus like area on the left outer foot requiring a hydrocolloid dressing.

R3's record included home health agency notes from the home health nurse regarding direction and concerns with the hydrocolloid dressing not

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01950	Continued From page 170	01950		

being in place with several visits.
Home health agency Care Communication note dated September 28, 2022, by home health licensed practical nurse read "New hydrocolloid dressing applied to left foot, dressing is to remain in place for 7 days. I re-wrapped his legs also. ***PLEASE tell your staff to leave the dressing on his left foot. For the past 3 weeks when we have come it has been off and either open to the air or has a corn pad on it. The hydrocolloid dressing is to remain on for 7 days, I wrote on the dressing to not remove it. Recommendations: Leave dressing in place or if it comes off, replace with a new one. Dressings are in a box in his room."

R3's Service plan/care plan dated August 16, 2022, in section Treatments/Therapies interventions indicated "Catheter care done as ordered/requested, See MAR/TAR/TASKS. Juxta wraps (compression wraps) to lower extremities done as ordered, See MAR/TAR/TASKS. See MAR/TAR and/or medication/treatment assessment and plan for resident specific information."

R3's Service plan/care plan dated August 16, 2022, in section Skin Condition indicated "Chronic skin conditions/scars: Ulcers on feet. Wound care is managed by [home health agency name] and [clinic name] wound clinic. Special skin issues-Interventions are: stoma care, nystatin powder to groin area for irritation."

R3's Documentation Survey Report v2 dated October 2022, on page two indicated a start date of October 5, 2022, for each shift (day, evening, night), "Hydrocolloid dressing to left foot."

The record did not provide clear or specific instruction for this task or for what ULP needed to

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01950	Continued From page 171 do if dressing was not in place. R3's record also included compression wraps with the instructions "compression wraps to be apply to both legs and feet with morning dressing. Put on slipper socks over the compression wraps. Compression wraps to be removed when resident prepares for bed." With a known history of lower extremity wounds, the licensee failed to provide written instructions for ULP to monitor and report any concerns with redness, skin breakdown or other concerns associated with the compression wraps. On November 3, 2022, at 5:00 p.m. RN-C stated the home health agency nurses managed R3's wound care about three times each week. RN-C stated "I often made visits with the home health nurse to see R3's wounds, but did not always document these visits. The recommendations from the home health nurse were entered into the "dashboard" for ULP to see. The leadership team provided daily summaries for the residents but delete after seven days." RN-C confirmed the entry in the task record was unclear and lacked specific directions for ULP to follow if the dressing was not in place. RN-C verified R3's record lacked clear instruction for ULP to reference regarding his compression wraps. R4 The licensee failed to provide written instructions for ULP reference for TED (thromboembolic deterrent) stockings/Ace wraps monitoring. R4's service plan/care plan dated November 1, 2022, indicated R4 received services to include assistance each morning and evening with TED stockings, ace wrap to lower right extremity as	01950		

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01950	Continued From page 172 needed. R4's diagnoses include unspecified dementia, psychotic disturbance (history of hallucinations), mood disturbance and anxiety, depression, age related osteoporosis (brittle/weak bones susceptible to fractures) with history of second lumbar vertebra compression fracture, asthma, dry eyes, hypertension (high blood pressure) and hypothyroidism (a condition with poor thyroid gland function). On November 1, 2022, at 10:55 a.m. the surveyor observed R4 not wearing TED stockings. ULP-I stated R4 often refused them or removed them herself. ULP-I stated, "They are not on today because they've been discontinued and the paperwork has not been changed." R4's service plan/care plan dated November 1, 2022, page five in section, Dressing intervention indicated, "Prefers assistance with putting on TEDS in the a.m. and removing TEDS in the p.m. as needed and as ordered by PCP [primary care provider]." Additionally, page nine in section Treatment intervention, indicated "TED hose/compression stockings applied as ordered. See MAR/TAR/TASKS as needed for edema." In R4's service plan/care plan in section of Skin Condition the intervention read, "Special skin issues. Interventions are: Staff assist weekly with shower and report any concerns to nursing." In the service plan/care plan in section of Treatments/Therapies the interventions/tasks read "See MAR/TAR and/or medication treatment assessment and plan for resident specific information. TED hose/compression stockings applied as ordered, See MAR/TAR/Tasks as needed for edema."	01950		

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01950	Continued From page 173 R4's Documentation Survey Report v2 dated October 2022, indicated for day shift and evening shift "Compression Stockings- Put on and off and wash out." This same record indicated as needed (PRN) use of an ace wrap to lower right extremity. Figure 8 beginning at toes up to knee. Apply tubigrips beneath wrap, on in a.m. off at p.m." R4's record lacked specific instruction for ULP to monitor regarding specific instruction for applying TED stockings and the Ace wrap to right lower extremity or when to report concerns or questions to nursing. On November 3, 2022, at 5:00 p.m. RN-C verified lack of direction and clear instruction for use of the TED stockings and Ace wrap and indicated the TED stockings were still an active treatment and ULP should have completed or communicated concerns. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain the required content in reference to 144G.72 Subd. 3. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations must be conducted by an RN and only unlicensed personnel who were determined competent and posses the knowledge and skills consistent with the complexity of tasks being delegated would be permitted to perform such tasks. The assisted living would have a system in place to communicate up to date information to a RN	01950		

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01950	Continued From page 174 regarding current available staff and their competencies. The licensee Temporary and Contracted Staff policy dated August 1, 2021, indicated temporary supplemental staffing would only be used if they meet the same requirements required as hired employees and would be treated as if they were staff of the facility. Competency evaluation results must be obtained for unlicensed personnel who would be assigned to perform delegated nursing services. Staff must be orientated tot he individual needs of each assigned resident, the service plan, methods of documentation, and other elements required to provide home care services. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01950		
01960 SS=D	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 the signature	01960		

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01960	Continued From page 175 and title of the person who administered the treatment or therapy and the date and time of administration for provision of treatment administration for one of three residents (R1) who was receiving treatment services. 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/care plan dated October 20, 2022, indicated R1 received services including "treatment/Therapies" which included TED [thromboembolic deterrent] hose/compression stockings (used to reduce swelling) applied as ordered. See MAR/TAR/Tasks. See MAR/TAR and/or medication/treatment assessment and plan for resident specific information. On November 1, 2022, at 8:36 a.m. unlicensed personnel (ULP)-I was observed to apply knee high TED stockings to R1's lower legs/feet. R1's record lacked documentation of staff providing the treatment service for TEDs. On November 3, 2022, 2:23 p.m. registered nurse (RN)-C stated, "Nope, there is no documentation" in R1's record of staff providing the treatment service for TEDs. RN-C stated R1 "was independent" with putting on TEDs. RN-C stated, "I'll have to add it."	01960		

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01960	Continued From page 176 The licensee's Medication and Treatment Record Documentation and Refusal policy dated August 1, 2021, indicated documentation of treatment/therapy administration would be completed by the person who performed the task immediately after the assistance/administration was completed. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01960		
01970 SS=E	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescriber's orders for treatment or therapy for three of three residents (R1, R3, R4) who were receiving treatment services. 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	01970		

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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/care plan dated October 20, 2022, indicated R1 received services including "treatment/Therapies" which included TED [thromboembolic deterrent] hose/compression stockings (used to reduce swelling) applied as ordered. See MAR/TAR/Tasks. See MAR/TAR and/or medication/treatment assessment and plan for resident specific information.

On November 1, 2022, at 8:36 a.m. unlicensed personnel (ULP)-I was observed to apply knee high TED stockings to R1's lower legs/feet.

R1's record lacked a prescriber order for the treatment service of TEDs.

On November 3, 2022, 2:23 p.m. registered nurse (RN)-C verified R1's record lacked a current prescriber order for TEDs. RN-C stated R1's prescriber order for TEDs was dated March 16, 2021, and was out dated.
R3
R3's record lacked an as needed order for hydrocolloid dressing for left foot.

R3's service plan/careplan dated August 16, 2022, indicated R3 received services that included daily lower extremity compression wrap assistance, suprapubic catheter site care and catheter bag management. Resident receives wound care and INR (international normalized ratio/lab calculation based on prothrombin test

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results; a test measuring how long it takes a blood clot to form in a blood sample) by an outside agency.

R3's diagnoses included heart failure, atrial flutter on warfarin (blood thinner to prevent blood clots), peripheral vascular disease (a condition where there is poor blood circulation to extremities), chronic kidney disease, benign prostatic hyperplasia with urinary retention and lower urinary tract symptoms (enlarged prostate causing poor bladder emptying), presence of suprapubic urinary stoma/catheter (opening to the bladder through the abdomen for urinary catheter placement), polyosteoarthitis (multiple locations of arthritis).

On November 2, 2022, at 7:00 a.m. ULP-Q was observed to provide compression wraps to both lower extremities, suprapubic catheter site care, urinary bag maintenance and exchange. The surveyor observed a small hydrocolloid dressing on left outer foot dated November 1, 2022. ULP-Q stated "The home health agency manages the dressing, there's an area on the side of his [R3] foot they are trying to soften, kind of like a callus or something. His other wounds have healed and they are working with just this one now." When the surveyor asked what the ULP role was with the hydrocolloid dressing, ULP-Q stated, "We just make sure it's there and if it's not, there's a corn pad in his cupboard we put on. The home health nurse comes and takes care of it otherwise."

R3's Documentation Survey Report v2 dated October 2022, on page two indicated a start date of October 5, 2022, for each shift (day, evening, night), "Hydrocolloid dressing to left foot."

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01970	Continued From page 179 R3's record included home health agency nurse notes dated from May 4, 2022, through October 20, 2022, indicated they managed R3's wound care for several lower extremity wounds. By October 2022, previously treated wounds on heels and toes had healed and the only area the home health agency was managing, was a callus like area on the left outer foot requiring a hydrocolloid dressing. R3's record included home health agency notes from the home health nurse regarding direction and concerns with the hydrocolloid dressing not being in place with several visits. Home health agency Care Communication note dated September 28, 2022, by home health licensed practical nurse read "New hydrocolloid dressing applied to left foot, dressing is to remain in place for 7 days. I re-wrapped his legs also. ***PLEASE tell your staff to leave the dressing on his left foot. For the past 3 weeks when we have come it has been off and either open to the air or has a corn pad on it. The hydrocolloid dressing is to remain on for 7 days, I wrote on the dressing to not remove it. Recommendations: Leave dressing in place or if it comes off, replace with a new one. Dressings are in a box in his room." On November 3, 2022, at 5:00 p.m. registered nurse (RN)-C stated the home health agency nurses managed R3's wound care about three times each week. RN-C stated the ULP responsibility was to replace the hydrocolloid dressing with another one in the event the dressing came off. RN-C stated "Even though the home health agency manages the dressings and wound care, we should have had an as needed order for the dressing on file for us to use." R4	01970		

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01970	Continued From page 180 R4's record lacked an order for TED stockings and lacked an updated/renewed order for ace wrap for right lower extremity. R4's service plan/careplan dated November 1, 2022, indicated R4 received services to include assistance each morning and evening with TED stockings and ace wrap to lower right extremity as needed. R4's diagnoses include unspecified dementia, psychotic disturbance (history of hallucinations), mood disturbance and anxiety, depression, age related osteoporosis (brittle/weak bones susceptible to fractures) with history of second lumbar vertebra compression fracture, asthma, dry eyes, hypertension (high blood pressure) and hypothyroidism (a condition with poor thyroid gland function). On November 1, 2022, at 10:55 a.m. the surveyor observed R4 not wearing TED stockings. ULP-I stated R4 often refused them or removed them herself. ULP-I stated, "They are not on today because they've been discontinued and the paperwork has not been changed." R4's service plan/care plan dated November 1, 2022, page five in section, Dressing intervention indicated, "Prefers assistance with putting on TEDS in the a.m. and removing TEDS in the p.m. as needed and as ordered by PCP [primary care provider]." Additionally, page nine in section Treatment intervention, indicated "TED hose/compression stockings applied as ordered. See MAR/TAR/TASKS as needed for edema." R4's Documentation Survey Report v2 dated October 2022, indicated for the day shift and evening shift "Compression Stockings- Put on	01970		

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01970	Continued From page 181 and off and wash out." This same record indicated the as needed (PRN) use of "Ace wrap to lower right extremity. Figure 8 beginning at toes up to knee. Apply tubigrips beneath wrap, on in a.m. off at p.m." On November 3, 2022, at 5:00 p.m. RN-C stated the ULP should still be attempting to put the TED stockings on as they are still an active treatment. RN-C provided an order for ace wraps dated January 6, 2021. The order read "DC [discontinue] previous order for ace wraps, and may use ace wraps for compression as needed, if stockings are not available. Please wrap from toe to knee in figure eight [8] fashion, provide soft padding beneath ace wraps for skin protection." RN-C stated she felt this order covered the TED stocking order since it was mentioned in the order. RN-C failed to recognize the order also needed to be renewed as it was due for renewal in January 2022. The licensee's Medication and Treatment Orders policy dated August 1, 2021, indicated the nurse was responsible for assuring current, authorized prescriber orders for treatments administered by staff are kept on file in the residents' records. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01970		
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:	02110		

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02110	Continued From page 182 (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in	02110		

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02110	Continued From page 183 for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 included: The licensee currently held an Assisted Living with Dementia Care license. R1, R2, R3 and R4's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including non-pharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and	02110		

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02110	Continued From page 184 efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On November 3, 2022, at 12:15 p.m. regional nurse specialist (RNS)-E stated "The policies for dementia care will be put into place today as it was not currently stated in the contract for this facility." No further information was provided TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02160 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (a) In addition to the minimum services required in section 144G.41, an assisted living facility with dementia care must also provide the following services: (1) assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition to the requirements in the licensing rules for the facility. Services must be provided in a person-centered manner that promotes resident choice, dignity, and sustains the resident's abilities; (2) nonpharmacological practices that are person-centered and evidence-informed; (3) services to prepare and educate persons living with dementia and their legal and designated representatives about transitions in	02160		

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02160	Continued From page 185	02160		

care and ensuring complete, timely communication between, across, and within settings; and
(4) services that provide residents with choices for meaningful engagement with other facility residents and the broader community.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure services were provided in a person-centered manner that promoted resident choice and dignity for one of four residents (R2) with records reviewed.

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

The findings include:

R2's diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions).

R2's service plan/care plan dated April 15, 2022, indicated R2 received services including activities, meals, assistance with transportation/appointments/shopping, pain, cardiac, bathing, grooming/oral hygiene, dressing/undressing, medication administration, weight monitoring, vitals, assistance with ambulation long distances, housekeeping, laundry, linen changes, daily bed making, fall

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interventions, assistance with safety in emergency situations, skin condition and bladder/bowel; would be able to maintain bladder/bowel function without assistance; is continent of bowels; is occasionally incontinent of bladder; reminders/cues to use toilet for voiding overnight; report to nurse any changes with bladder/bowel incontinence; uses incontinence products: pull-up; supply and disposal managed by resident/family/staff; dispose of used incontinent products every shift.

R2's 90 Day Review assessment dated September 30, 2022, indicated for toileting needs:appropriate, which were reviews of R2's Annual Assessment dated January 8, 2022, and indicated for Bowel and Bladder; resident is incontinent of bladder; resident prefers prompted toileting and prefers use of depends and recap of health status since last review included "since last review, she has escorts to meals and activities outside of [locked unit]. She is independent with ADLs [activities of daily living] with checks to ensure ADLs are completed, clothing clean and appropriate. She enjoys spending time socializing with other resident in [locked unit]/ Also enjoys attending live to be healthy when it is offered. She is independent with ambulation at this time. Resident affect remains unchanged and she is stable."

On November 1, 2022, at 7:38 a.m. unlicensed personnel (ULP)-H was observed to assist R2 with dressing, toileting and hygiene. ULP-H with gloves on changed R2's disposable incontinent brief and wiped R2's buttocks area. ULP-H stated to R2 "you did have a little bit of BM [bowel movement]". ULP-H assisted R2 with pants and removed gloves. ULP-H applied clean gloves and assisted R2 to use mouthwash and washed R2's

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02160	Continued From page 187 face with a wash cloth. During the observation R2 stated, "I'm not used to having other people dress me." ULP-H stated, "I know, but let me help you." R2 stated (after ULP-H finished assisting R2), "I'm not used to this. I'm used to doing myself." On November 1, 2022, at 12:44 p.m. RN-C stated R2 required for assistance with activities of daily living (ADL'S)/morning cares "more than anything cues or reminders, than assistance of one". RN-C stated staff should physically set up clothes and toothbrush for R2 and give cues to R2. RN-C staff should promote independence with cares. RN-C stated, "We do promote independence with all residents." The licensee's Resident Handbook dated August 1, 2021, indicated page four "Assisted living includes encouragement of family involvement, resident self-direction, and resident participation in decisions that emphasize choice, dignity, privacy, individuality, shared risk, and independence." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02160		
02170 SS=D	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;	02170		

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02170	Continued From page 188 (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 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 interview and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions for two of two residents (R2, R4) who received services under an assisted living with dementia care license, and failed to develop an individualized activity plan based on the evaluation for two of two residents (R2, R4).	02170		

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02170	Continued From page 189 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: The licensee held an assisted living with dementia care license effective August 1, 2022. On October 31, 2022, at 10:00 a.m. during the entrance conference, regional director of operations and sales (RDOOS)-B stated the facility's previous life enrichment coordinator had left and the current culinary coordinator was moving into this role and had just started training. R2 R2's diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). R2's service plan/care plan dated April 15, 2022, indicated R2 received services including activities and indicated staff may choose any spontaneous activity available according to what the resident seems to be receptive to or customarily enjoys, encourage resident to attend activities that they like, encourage and assist in attending and participating in group activities, needs assistance/escort to and from activities outside of memory care unit, preferred activities are: devotion, church, read aloud's, bible study, socials, music, exercise, crafting.	02170		

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02170	Continued From page 190 R2's record lacked an evaluation of 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, R2's record lacked the development of an individualized activity plan. R4 R4's diagnoses included unspecified dementia, psychotic disturbance (history of hallucinations), mood disturbance and anxiety and depression. On November 2, 2022, at 1:00 p.m. ULP-I stated "all [R4] does is sleeps and sits at the table. [R4] and the other residents in here (memory care) don't like to do much other than watch TV, eat, and sleep. We have music on Tuesdays, some residents participate." R4's service plan/care plan dated November 1, 2022, indicated R4 received services including escort to and from dining area and activities and indicated for activities: resident would participate in activities of choice in the community, staff may choose any spontaneous activity available according to what the resident seems to be receptive to or customarily enjoys. Encourage and assist in attending and participating in group activities as needed ad to be increased with decline. Needs assistance /escort to and from activities. Under Activities tasks/interventions: preferred activities are: read, bingo, cribbage. R4's record lacked evidence the resident had	02170		

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02170	Continued From page 191 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, R4's record lacked the development of an individualized activity plan. On November 3, 2022, at 12:15 p.m. regional nurse specialist (RNS)-E stated she looked for more information from the previous life enrichment coordinator and was not able to find a "life story" or other evidence of a completed activities assessment completed for R2 and R4. On November 3, 2022, at 5:00 p.m. RNS-E stated the ULP weren't always aware that some of the "random activities" they do, like coffee time and chat counted as an activity. Music therapy visited the memory care unit one to two times each week, and the "live to be healthy" (exercise) program was provided three times each week. The licensee's ALDC Life Enrichment Programs, Activities and Outdoor Space policy (3.05) dated August 1, 2022, indicated as an assisted living with dementia care licensed facility, the corporations communities strive to provide valuable activities and life enrichment programs for residents with Alzheimer's disease and other dementias. Each resident must be evaluated for activities according to the licensing rules of the facility. An individualized activity plan must be	02170		

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02170	Continued From page 192 developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02180 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Access to secured outdoor space and walkways that allow residents to enter and return without staff assistance must be provided. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure behavioral symptoms were identified and were addressed on the care plan for two of two residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	02180		

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02180	Continued From page 193 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee held an assisted living with dementia care license, effective August 1, 2022. R2 R2's diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). R2's service plan/care plan dated April 15, 2022, indicated R2 received services including administration of medications and vulnerability of "anxiety/depression/mental illness vulnerability interventions are: resident has diagnoses of Alzheimer's dementia and depressive disorder. Has periods of increased confusion and anxiety. Medications are administered per prescriber's orders and monitored for efficacy. Staff provide visits when change in baseline is noted." On November 1, 2022, at 7:31 a.m. ULP-I was observed to administer medications to R2. R2's MAR dated October 2022, indicated staff were administering escitalopram (antidepressant used to treat depression and generalized anxiety disorder) 10 milligrams (mg) one time a day for major depressive disorder and risperidone (antipsychotic medication used to treat schizophrenia, bipolar disorder, or irritability associated with autistic disorder) 0.25 mg at bedtime for Alzheimer's disease. R2's service plan/care plan lacked specific behaviors/symptoms and non-pharmalogical interventions to implement for behavioral	02180		

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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
02180	Continued From page 194	02180		

symptoms that negatively impact the resident and others.

On November 3, 2022, 2:23 p.m. RN-C and RNS-E verified R2's record lacked the above.

R4
R4's diagnoses included unspecified dementia, psychotic disturbance (history of hallucinations), mood disturbance, anxiety and depression.

R4's service plan/careplan dated November 1, 2022, indicated R4 received services to include medication management, with vulnerabilities to include anxiety and depression. Vulnerablility interventions included 24/7 supervision in the memory care unit and medications managed and administered by facility staff.

R4's medication orders signed and dated September 22, 2021, included an order for quetiapine (antipsychotic medication used to manage agitation and hallucinations) 25 mg - give 0.5 (one half) tablet by mouth as needed for delirium.

R4's hospice medication orders dated August 30, 2022, indicated R4 received scheduled quetiapine 25 milligram (mg) 0.5 tablet every evening at bedtime and quetiapine 25 mg, give 0.5 tablet once daily as needed for agitation.
Additionally, R4's hospice medication orders dated August 30, 2022, included lorazepam 0.5 mg every four hours as needed for anxiety.

R4's MAR dated October 2022, indicated R4 received medications including one for depression, one for hallucinations/agitation, one for anxiety, one for sleep, one for hypothyroidism (a condition with poor thyroid gland function), two

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	24053	A. BUILDING: _____ B. WING _____	11/04/2022

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02180	Continued From page 195 for asthma, one for itching skin, four for pain, and one nutritional supplement drink, one for constipation, one cream for dry skin, one for excessive secretions, and one for nausea. On November 1, 2022, at 10:55 a.m. ULP-I was observed to administer medications to R4. R4's record lacked documentation explaining the change of R4's quetiapine from an as needed medication to a scheduled dose with an additional as needed dose. R4's service plan/care plan lacked specific behaviors/symptoms and non-pharmalogical interventions to implement for behavioral symptoms that negatively impact the resident and others. On November 3, 2022, at 4:10 p.m. RN-C and RNS-E confirmed R4's service plan/careplan lacked description of behavioral symptoms. The license's ALDC (assisted living dementia care) Behavioral Symptoms, Interventions and Nonpharmacological Approaches policy dated August 1, 2021, indicated the licensee supports person-centered and evidence based evaluation of behavioral symptoms and design of supports for intervention plans; including nonpharmacological interventions or practices in the following ways: would identify behavioral symptoms that negatively impact other residents and others in an assisted living facility and evaluate to determine potential interventions to minimize such behaviors. Interventions would be identified on the care plan or service plan. No further information was provided.	02180		

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02180	Continued From page 196 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02180		
02290 SS=E	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee included within the resident record language which waived claim against the licensee for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1, R2, R3 and R4's Move In Record sheet identified "Trip" waiver language "I do waive any claim against the Community, or any staff member, or volunteer furnishing rides, or supervision for the trip, for any damage to or of property, or injury."	02290		

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02290	Continued From page 197 On November 3, 2022, at 2:45 p.m. regional nurse specialist (RNS)-E stated, "This waiver needs to be removed from point click care as it is not applicable and we are unable to remove it ourselves". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02290		
03000 SS=E	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 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	03000		

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03000	Continued From page 198	03000		

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) a suspected maltreatment for one of one resident (R2) and significant medication errors for two of two residents (R1, R3).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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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03000	Continued From page 199	03000		

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

The findings include:

R2
R2's service plan/care plan last reviewed April 15, 2022, included assistance with activities of daily living and administration of medications.

R2's incident report dated August 7, 2022, indicated resident assistant (RA) witnessed a resident with a cup that contained bleach. "Resident states she drank some of it." The registered nurse (RN) on call was notified. RN asked if the resident had any signs of ingesting the bleach. The resident did not appear to have any odor of bleach on her. Poison control was called and stated that if the resident had ingested bleach, she would have burns on her mouth. The resident did not have any signs of ingesting bleach. A family member was notified and did not wish to have R1 sent into the emergency room (ER). RN instructed staff to continue to monitor R1 for nausea and vomiting throughout the night. The report further indicated the laundry room door had been left open. "RN reiterated to staff the importance of keeping the laundry room door closed and lacked to keep chemicals away from resident's."

The licensee failed to ensure immediate report of the incident to MAARC.

On November 3, 2022, at 1:33 p.m. RN-C and Regional nurse specialist (RNS)-E stated the licensee's process for incidents was to fill out an incident report, notify the doctor, notify family, talk to staff and provide education. RN-C stated she

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03000	Continued From page 200	03000		

had not filed a report to MAARC regarding the incident. RN-C stated R2 "did not drink bleach," as the poison control center informed if R2 had drank some of the bleach, R2 would of had "burns and blisters inside mouth." When asked if the incident had been reported to MAARC, RNS-E stated, "I don't recall this one." When asked when a MAARC report would be reported, RNS-E stated, "If negative outcome, make a MAARC report."

R1
R1's service plan/care plan dated October 20, 2022, included medication administration, insulin administration and blood sugar checks.

R1's Medication Error report dated June 14, 2022, documented by licensed practical nurse (LPN)-R, indicated she received a call from the RA informing the resident's insulin was still on hold. Most of the other medications were taken off hold when the resident returned from the hospital. The resident's blood sugar was 345. The RN who received the resident back to the community was contacted. "She instructed to take Lantus 24 units off hold." A phone call was placed to the doctor on call to verify how many units of insulin was to be given. The doctor on call "after review of resident hospital stay and discharge papers informs that 10 units of Lantus was to be given." The doctor was informed R1 received 24 units of Lantus at 1945 (7:45 p.m.) The doctor gave a verbal order to recheck blood sugar at 2145 (9:45 p.m.) If above 120, no further action needed tonight. Recheck on blood sugar was 249.

R1's After Visit Summary dated June 1, 2022, through June 14, 2022, indicated Lantus 10 units under the skin at bedtime. Last time this was

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03000	Continued From page 201 given: 10 units on June 13, 2022, 7:00 p.m. The licensee failed to ensure immediate report of a significant medication error to MAARC. On November 3, 2022, at 8:41 a.m. LPN-R stated, "Yes, [R1] returned from the hospital" on June 14, 2022. LPN-R stated R1's family member "sat orders on [RN-C's] desk " and RN-C stated "she would take care of them" and "asked me to fax two to three orders to the pharmacy. I got a call [from staff person] insulin was still on hold" (in the computer system) and I informed the staff person to call RN-C. RN-C "told the staff person to tell [LPN-R] to take the insulin off hold. I was not comfortable with that, so I texted [RN-C] and asked if the dose was right" and RN-C "said it was right, take off hold. So I did. My gut said I shouldn't have done that. I couldn't find anything in the system [regarding orders upon return from the hospital], so I called the on-call doctor to verify the dose to be given and informed [R1] had received 24 units instead of 10 units." On November 3, 2022, at 1:33 p.m. RN-C stated, "After coming back from the hospital [R1's] insulin was reduced due to after surgery [R1] was not eating as much. Orders were sent back with her and I asked [LPN-R] to enter [into the licensee's computer system] and fax the pharmacy. Re-entering the medication orders [into the licensee's computer system] did not happen. RNS-E stated, "Guidance if negative outcome would report. No negative outcome with glucose monitoring." RNS-E stated, "No" to the incident being reported to MAARC. R3 R3's service plan/care plan dated August 16, 2022, included administration of medications and	03000		

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03000	Continued From page 202 INR (international normalized ratio/lab calculation based on prothrombin test results; a test measuring how long it takes a blood clot to form in a blood sample) by an outside agency. R3's Medication Error report dated June 10, 2022, indicated resident's last dose of warfarin was on Thursday, June 9, 2022. R3 was unaware that he did not receive his warfarin. The med passer informed nursing that warfarin was not on E-MAR(electronic medication administration record) to be given. R3's Medication Administration Record (MAR) dated June 2022, identified no signatures by the staff for administration of warfarin for the dates of June 9, 10, 11, and 12, 2022. R3's clinic notes indicated the following: -dated June 8, 2022, indicated results for INR was "2.5" and anticoagulation dosing "Goal:2-3". New warfarin dosing: warfarin 1.5 milligrams (mg) Sunday; and warfarin 2.5 mg Monday, Tuesday, Wednesday, Thursday, Friday and Saturday. Recheck INR one week June 15, 2022. -dated June 13, 2022, discontinue previous warfarin orders due to missed dosing; start warfarin 5 mg daily Monday and Tuesday. Recheck INR on Wednesday June 15, 2022. -dated June 15, 2022 INR value today "1.6. Goal: 2-3". Warfarin 2.5 mg Wednesday, Thursday, Friday, Saturday, Sunday, Tuesday and 1.5 mg on Monday. Recheck INR one week June 22, 2022. R3's INR value fell below the goal of "2-3" on June 15, 2022, due to missed doses of warfarin. The licensee failed to ensure immediate report of a significant medication error to MAARC.	03000		

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03000	Continued From page 203 On November 3, 2022, at 8:41 a.m. LPN-R stated even though R3's MAR showed R3 did not receive medication on the dates of June 9, 10, 11 and 12, 2022, R3 had received warfarin on June 9, 2022. LPN-R stated, "I saw from the pack dose June 9 dose was given, but the staff person was unable to sign for giving the medication because the medication was not on the EMAR." LPN-R stated R3's INR on June 8 was "2.5 and on June 15 was "1.6". LPN-R stated, "Yes, [R1's INR] dropped". LPN-R stated regarding if the medication error had been reported to MAARC, "I'm going to say no, didn't even think about it." On November 3, 2022, at 1:33 p.m. RNS-E stated regarding if the medication error had been reported to MAARC, "I'm usually involved in any VA [vulnerable adult/report] done. I don't recall one." The licensee's Vulnerable Adult Maltreatment Prevention and Reporting policy dated August 1, 2021, indicated maltreatment was defined as neglect, abuse, and exploitation/theft. Staff who suspect maltreatment of a resident (abuse, financial exploitation, or neglect), or who has knowledge that a resident has sustained a physical injury which is not reasonably explained would "f. If the assisted living director or nurse confirms the suspicion of maltreatment, they will contact the Minnesota Adult Abuse Reporting Center (MAARC). Such report must be made no later than 24 hours after the maltreatment was first suspected." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

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03090	Continued From page 204	03090		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 31, 2022, at 9:45 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices.	03090		

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03090	Continued From page 205 On October 31, 2022, at 11:37 a.m., during tour of the facility with registered nurse (RN)-C, RN-C stated, "We don't have any video cameras." RN-C stated she was "not aware" of the electronic monitoring device notice requirement. The licensee's Electronic Monitoring policy dated August 1, 2021, indicated the licensee would support the use of electronic monitoring by our residents and resident representatives (as defined by law). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Food, Pools, Lodging
18 Woodlake Dr. SE
Rochester
507-206-2700

Type: Follow-Up
Date: *11/02/22*
Time: 08:11:44
Report: 8074221197

Food and Beverage Establishment Inspection Report

Location:
Abilit Holdings (Prairie Meado
800 5th Ave Nw
Kasson, MN55944
Dodge County, 20

Establishment Info:
ID #: 0037702
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5007634950
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.

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

No quat or peroxide test kit.

Comply By: 11/02/22

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

spray sink needs to be resealed to wall.

Comply By: 11/09/22

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

Wall by plumbing under sink in neighborhood kitchen needs to be sealed around plumbing.

Comply By: 11/02/22

Surface and Equipment Sanitizers

Hot Water: = at 182 Degrees Fahrenheit
Location: rinse manifold
Violation Issued: No

Hot Water: = at 179 Degrees Fahrenheit
Location: rinse internal
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 157 Degrees Fahrenheit - Location: soup
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 34 Degrees Fahrenheit - Location: soup
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 35 Degrees Fahrenheit - Location: beans
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: fruit salad, butter, lettuce
Violation Issued: No

Process/Item: Milk Dispenser
Temperature: 36 Degrees Fahrenheit - Location:
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: cottage cheese
Violation Issued: No

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

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 8074221197 of 11/02/22.

Certified Food Protection Manager: Teri McIntire

Certification Number: FM18095 Expires: 06/28/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Andrea Kieffer

507-206-2721
andrea.kieffer@state.mn.us