Electronically Delivered

August 9, 2023

Licensee
PSC Of Isanti, LLC
706 6th Avenue Northeast
Isanti, MN 55040

RE: Project Number(s) SL30809015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 19, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH 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 (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 survey:

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

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.

The correction order documentation should include the following:

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30809	A. BUILDING: _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PSC OF ISANTI LLC	706 6TH AVENUE NE ISANTI, MN 55040

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30809015-0 On July 17, 2023, through July 19, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 37 active residents; all of whom were receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 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 two of four employees (unlicensed personnel (ULP)-G, ULP-K) during personal cares for R11 and R8; and one of one employee (ULP-J) during a dressing change for R14. In addition, the licensee failed to ensure one of one employee (ULP-L) disinfected shared equipment between resident use. 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: PERSONAL CARES On July 17, 2023, at 2:04 p.m., the surveyor observed ULP-G and ULP-C enter R11's room. ULP-G and ULP-C transferred R11 from her	0 510		

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0 510	Continued From page 2 wheelchair to her bed using a mechanical lift. ULP-G and ULP-C donned a pair of gloves. ULP-G lowered R11's pants and unattached R11's brief. ULP-C and ULP-G positioned R11 on to her left side. ULP-G removed R11's wet brief and placed it in a nearby garbage can. ULP-G using gloved hands and several disposable wipes cleaned R11's bottom and provided peri-care. ULP-G placed a clean brief under R11. ULP-G and ULP-C positioned R11 on to her right side and then onto her back while positioning the clean brief under R11's bottom. ULP-C pulled R11's pants up and repositioned R11's bed. ULP-C removed her gloves and went into the bathroom and washed her hands. ULP-G with the same gloved hands proceeded to touch R11's face and remove R11's glasses placing them on the dresser. ULP-G with the same gloved hands retrieved R11's bed/chair alarm box from the wheelchair, reattached the alarm box to the bed alarm and placed the box on the windowsill. ULP-G then went into the bathroom, removed her gloves, and washed her hands. On July 17, 2023, at 2:19 p.m., ULP-G stated she had not changed her gloves and performed hand hygiene after she had provided incontinence care and prior to removing R11's glasses and setting up R11's bed alarm. ULP-G stated she should have removed her gloves right after providing incontinence care and washed her hands. On July 18, 2023, at 8:07, the surveyor observed ULP-K remove R8's soiled brief with gloved hands. With the same gloved hands, ULP-K removed R8's oxygen tubing off R8's nose, removed R8's clothing, and the removed gloves. ULP-K walked out the door to go find another ULP for assistance. At 8:10 a.m., ULP-K returned and donned a new pair of gloves without hand	0 510		

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0 510	Continued From page 3 hygiene. ULP-K then completed a bath, including washing and conditioning R8's hair. ULP-K then removed wet gloves and donned a new pair with no hand hygiene. ULP-K assisted R8 with drying off, dressing, and transferring. At 8:34 a.m., ULP-K removed gloves, did not wash hands and assisted R8 with pulling up R8's brief and pants without donning gloves. On July 18, 2023, at 9:38 a.m., ULP-K stated hands should have been washed in between changing gloves. DRESSING CHANGE On July 18, 2023, at 7:54 a.m., the surveyor observed ULP-J provide wound care services to R14's right medial knee area. ULP-J used hand sanitizer prior to entering R14's room. R14 was laying in his bed. ULP-J donned a pair of gloves and with ULP-G's assistance lowered R14's bed coverings and removed the pillow that was positioned between R14's knees. ULP-J with gloved hands removed R14's dressing on his right medial knee area. The dressing was saturated with purulent drainage (yellow tinged drainage from a wound). R14 had two open wounds on the medial aspect of his right knee. R14's surrounding skin around the wound was reddened and the wound had purulent drainage with slough (a layer of dead tissue separating from the surrounding or underlying tissue). Using the same gloved hands ULP-J sprayed wound cleanser on a dry gauze pad and cleansed R14's wound. ULP-J with the same gloved hands opened the package of a new border dressing. The surveyor observed ULP-J to touch the gauze part of the dressing with her soiled gloves. ULP-J then applied the border dressing to R14's right medial knee wound. ULP-J removed her gloves and immediately donned a new pair without	0 510		

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0 510	Continued From page 4 performing hand hygiene after the glove removal. ULP-J and ULP-G proceeded to transfer R14 with a sit to stand to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability) from his bed to the toilet. The surveyor observed ULP-J to don and doff her gloves several times during assisting R14 with toileting, dressing, and transferring back to his wheelchair. ULP-J did not perform hand hygiene following each glove removal. ULP-J prior to exiting R14's room removed her gloves and washed her hands in the resident's bathroom. On July 18, 2023, at 8:29 a.m., ULP-J stated she did not change gloves and wash her hands after removal of R14's soiled dressing and she should have. ULP-J stated she should also wash her hands or use hand sanitizer each time she removed her gloves. On July 18, 2023, at 2:37 p.m., director of regulatory compliance (DRC)-D stated staff should perform hand hygiene in between resident cares and each time they removed their gloves. The licensee's Hand Hygiene policy dated August 1, 2021, noted hands should be washed or decontaminated before and after direct contact with a client; if moving from a contaminated body site to a clean body site during client care; and after removing gloves. The licensee's Procedure for Using Gloves policy dated August 1, 2021, indicated if gloves become torn or heavily soiled and additional tasks must be performed for the client, then change the gloves (washing hands before putting on new gloves before starting the next task). The licensee's Standard Universal Precautions	0 510		

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0 510	Continued From page 5 for Infection Control policy dated August 1, 2021, indicated hand washing is crucial and staff will wash hands before putting on gloves and immediately after gloves are removed. REUSABLE MEDICAL EQUIPMENT On July 18, 2023, at 9:27, the surveyor observed ULP-L complete R12's blood pressure reading. ULP-L placed the blood pressure cuff on R12's wrist, when the reading was complete ULP-L placed the blood pressure cuff back in the container and placed it in a basket in the caregiver's office. The surveyor did not observe ULP-L clean the shared blood pressure cuff before or after use. On July 18, 2023, at 11:20 a.m., the surveyor observed ULP-L complete R13's vital signs. ULP-L used a shared resident blood pressure cuff, a shared resident thermometer for the forehead, and a shared resident pulse oximeter. ULP-L completed R13's vital signs and returned the shared equipment back to the basket in the care givers office. The surveyor did not observe ULP-L clean the shared equipment before or after use. On July 18, 2023, at 11:31 a.m., ULP-L stated the vital sign equipment was not cleaned before or after each resident use and has not been done since Covid precautions have been lifted. On July 18, 2023, at 2:37 p.m., DRC-D stated shared vital sign equipment should be cleaned before and after each resident use. The licensee's Disinfecting Reusable Equipment and Environmental Surfaces policy dated August 1, 2021, indicated after using reusable equipment, the equipment must be cleaned per	0 510		

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0 510	Continued From page 6 manufacturer's instructions and returned to the place that it is stored. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and 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 and interview, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 550		

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0 550	Continued From page 7 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 17, 2023, at 11:36 a.m., the surveyor toured the facility with campus director (CD)-E. The bulletin board at the main entrance had the facility's grievance procedure (Suggestions, Concerns, and Grievances) posted; however, the grievance procedure posted did not include the required content to include the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. CD-E stated the above noted information was not posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 620 SS=D	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 observation, interview, and record review, the licensee failed to submit a report to	0 620		

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0 620	Continued From page 8 the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R3) who eloped and had incidents of resident-to-resident altercations. 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 held a current assisted living with dementia care (ALDC) license. On July 17, 2023, at 11:20 a.m., the surveyor asked clinical nurse supervisor (CNS)-B to provide the MAARC and incident reports for the last six months. The Incident Summary log dated January 31, 2023, through July 17, 2023, indicated R3 eloped on May 3, 2023, at 2:30 p.m., sustained a fall on January 31, 2023, and an "other injury" on June 25, 2023. No MAARC reports were provided. R3's diagnoses included vascular dementia with behavior disturbance, chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing) and hypothyroidism. R3's service plan dated October 11, 2022, indicated the resident received services to include medication administration, fall prevention/safety checks, vital sign monitoring, assistance with bathing, morning/evening cares, housekeeping,	0 620		

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0 620	Continued From page 9 and laundry. R3's Clinical Update Assessment dated May 11, 2023, indicated R3 needed a locked memory care unit, required supervision from trained staff, assistance with medication administrations, and activities of daily living (ADL). The section under "Elopement History" was blank. R3 was identified as having four falls in the last three months with the last fall being on January 31, 2023. R3 was to have safety checks completed every two hours during the day and one hour at night. Staff were directed to check the security on doors, gates, and alarms. R3 was identified as having a balance problem with standing, and walking and was to always have his walker with him during transfers and ambulation. R3 was identified as an elopement/wandering risk. R3 had a history of wandering at previous facility and staff were to be aware of R3's location. R3's pattern of wandering was identified as wanders inside, occasionally into other's rooms, but does not leave the building. Staff were directed to intervene if R3 was found in other resident's rooms, and escort him back to the common areas. Staff were to always know R3's whereabouts. R3's Clinical Update Assessment dated July 14, 2023, indicated the same information above, however, indicated R3 had an elopement attempt on May 3, 2023, staff were to be aware of resident's location and had one fall in the last three months. R3's individualized abuse prevention plan (which was incorporated into R3's Clinical Assessments noted above) indicated R3 was at risk to be abused by others and was at risk to abuse other vulnerable adults. It was noted the facility's environment was designed to minimize stress	0 620		

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0 620	Continued From page 10 that could cause agitation and the staff had been professionally trained to deal with dementia-influenced behavior. The staff would attempt to diffuse and redirect aggressive behaviors. The facility had policies in place to protect residents from aggressive behaviors in most instances. In addition, it was noted all staff at the facility were mandated reports of suspected abuse. R3's Elopement report dated May 4, 2023, indicated resident was outside of the enclosed fenced area wandering on May 3, 2023. The last safety check was done at 2:15 p.m. Staff coming onto their shift found R3 around 2:30 p.m., wandering with his walker in the unsecure parking lot of the facility. Staff were able to redirect him back into the building with no concerns. During the investigation it was found the outside fence doors lock had failed and R3 was able to leave through the gate with no resistance, maintenance was notified and placed a bike lock onto the fence door until the fence company could come and fix the lock issue. It was noted in the "Other Info?" section that R3 was completely unaware of what he was doing at the time. R3 does not attempt to elope, likes to check all the doors in the building due to curiosity but never tries to leave. On July 18, 2023, at 11:42 a.m., director of regulatory compliance (DRC)-D and maintenance director (MD)-I showed the surveyor where R3 had exited the secure grounds of the facility on May 3, 2023. MD-I stated R3 had exited the outside patio area through a gate in which the magnetic lock was malfunctioning making the gate unsecure. DRC-D stated it appeared R3 had lifted the latch on the gate and was able to exit the gate into the adjacent parking lot. Observed directly to the right of the parking lot	0 620		

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0 620	Continued From page 11 was an embankment which went down into a swampy area. DRC-D stated an elopement was never "good". No MAARC report was provided for this incident of elopement. R3's Fall report dated February 2, 2023, noted R3 was standing in the "Beachside" living room when another resident (R16) came up to R3 and pushed him, causing R3 to fall onto his bottom/side. It was also documented there was no witnesses to the fall; no injuries; and there was a pattern noted as R16 has "it out for this resident [R3] pushing him [R3] and causing him [R3] to fall". No MAARC report was provided for this incident. R3's Other Injury report dated June 25, 2023, noted R3 went into another resident's room. The staff heard a noise coming from the other resident's room. R3 was found to have a scratch on his back/neck area. "It was apparent that other resident became aggressive with [name of R3]." No MAARC report was provided for this incident. On July 18, 2023, at 3:01 p.m., campus director (CD)-E stated a MAARC report should be filed within 24 hours of knowledge of an event that would be any suspected abuse or maltreatment. Chief operating officer (COO)-M stated a MAARC report was only filed when a resident needed to seek medical attention. On July 18, 2023, at 3:03 p.m., COO-M stated no MAARC reports had been filed involving R3.	0 620		

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0 620	Continued From page 12 On July 18, 2023, at 3:55 p.m., CNS-B stated a MAARC report should be completed within 24 hours of an incident resulting in an injury. CNS-B stated she would also consider any elopement a reportable event that should generate a MAARC report. CNS-B reviewed R3's three incidents noted above. CNS-B stated she was unsure why R3's elopement incident on May 3, 2023, wasn't reported to MAARC. CNS-B stated on review of the above noted incidents involving R3, CNS-B stated "all three of these incidents probably should have been reported" to MAARC. The licensee's Vulnerable Adult Maltreatment Policy dated June 1, 2023, noted the organization would create an environment and process to identify, prevent, and mitigate maltreatment of vulnerable adults. Any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately to their supervisor, a nurse, or the LALD (licensed assisted living director) and that person will complete an incident report. If the incident appears to be suspected of abuse, neglect, or financial exploitation, LALD or CNS will immediately make a report to the CEP (common entry point). "Immediately means as soon as possible, but no longer than 24 hours from the time the LALD or CNS received initial knowledge that the incident occurred. If it is unclear based whether maltreatment has occurred, and investigation into the incident will begin immediately. If within the 24 hours following the initial incident report, it is still unclear whether reportable maltreatment has occurred, a report will be made to the CEP. All staff are educated on report of suspected maltreatment and their obligation to report as mandated reporters. Education includes internal reporting process and the choice to report directly to the	0 620		

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0 620	Continued From page 13 CEP. The licensee's Missing Resident Policy dated June 13, 2023, in the event a resident elopes from the facility and/or is missing it was identified in the policy within 24 hours of the incident, report to MAARC. The licensee's Wandering and Egress Prevention in ALDC policy, dated January 31, 2023, noted it was the policy of the facility to assure safe wandering and safeguard against egress/elopement. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
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	0 680		

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0 680	Continued From page 14 orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's EPP dated April 4, 2023, did not include written agreements or contracted arrangements with other facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to facility residents. The tab in the EPP binder labeled "MOUs" [Memorandums of Understanding] was blank. On July 18, 2023, director of regulatory compliance (DRC)-D stated the facility's MOUs had not been signed yet.	0 680		

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0 680	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms inside resident	0 780		

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0 780	Continued From page 16 sleeping units throughout building B. This has the potential to directly affect all residents, staff, and visitors in building B. 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 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 residents). The findings include the following: On July 19, 2023, between 10:45 a.m. and 1:30 p.m., survey staff toured the facility with the maintenance director (MD)-I. During the tour, survey staff observed inside each resident sleeping unit (all open floor plan type sleeping units) throughout building B failed to have the required smoke alarm for local notification. The MD-I verbally confirmed survey staff observations during the facility tour. On July 19, 2023, at approximately 2:30 p.m., the campus director-E, the director of regulatory compliance-D, and the chief operating officer-M acknowledged the above findings during the exit interview. No further information was provided. Period FOR CORRECTION: Twenty-one (21) days	0 780		
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 17 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. 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 July 19, 2023, between 10:45 a.m. and 1:30 p.m., survey staff toured the facility with the maintenance director (MD)-I. During the tour survey staff observed the following: -The two fire-rated doors (1.5 hour) to the commercial kitchen/dining areas were wedged in the open position preventing the doors to close for proper separation during a fire as designed.	0 800		

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0 800	Continued From page 18 -The fire-rated salon room door failed to positively latch when closed to protect and maintain the smoke-tight integrity of the corridor. -The laundry room (building B) was wedged open for hazardous area protection. -A three-tier shelf was improperly located in front of the electrical switches in the electrical room (building B) preventing ready access for use during an emergency. -Space heaters were observed inside resident sleeping units 120 and 220 (building A) and room 223 (building B). Survey staff explained that space heaters are not allowed inside resident rooms under the state standards for this type of occupancy (dementia care). -The bathroom door in resident sleeping unit 214A/B rubbed on the floor preventing the bathroom door from closing completely for resident privacy (6-inch wide opening between door and wall). The above findings were visually and/or verbally verified by the MD-I accompanying the tour. On July 19, 2023, at approximately 2:30 p.m., the campus director-E, the director of regulatory compliance-D, and the chief operating officer-M acknowledged the above findings during the exit interview. No further information was provided. 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	0 810		

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

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0 810	Continued From page 20 affect the safety of staff, visitors, and all residents receiving care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 19, 2023, from approximately 1:30 p.m. to 2:00 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review. -Document review indicated that the licensee failed to provide the minimum evacuation drills for compliance with the requirement of every other month frequency. Drill records provided for review had 4-month frequencies (10/7/2022 to 2/17/2023 and 3/1/2023 a.m. and p.m. to no drills to date). Survey staff explained that the employee evacuation drills must be performed at least one evacuation drill every other month in addition to the two evacuation drills per shift per year. Drills must also include evacuation drills. Fire drills and evacuation drills may be combined when conducting drills. - Document review indicated documentation lacked employee training on the fire safety and evacuation plan at least twice per year (after new hire training). Survey staff received training records on severe storms and tornadoes dated 3/10/2023, but no records were provided to support the training on fire safety and evacuation plan.	0 810		

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0 810	Continued From page 21 On July 19, 2023, at approximately 2:30 p.m., document review and interview with the campus director-E, the director of regulatory compliance-D, and the chief operating officer-M confirmed and acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty (21) days	0 810		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support	0 940		

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0 940	Continued From page 22 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 observation, interview, and record review, the licensee failed to ensure the assisted living contract included all required content for one of one resident (R8). This had the potential to affect all residents who received assisted living services. 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: During the entrance conference on July 17, 2023, at 11:20 a.m., the surveyor requested a copy of the assisted living contract, which was later provided for review. R8's service plan dated June 28, 2023, indicated services included medication administration, blood glucose monitoring, oxygen maintenance, assistance with bathing and transfers, and	0 940		

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0 940	Continued From page 23 laundry. On July 18, 2023, at 7:53 a.m., the surveyor observed unlicensed personnel (ULP)-L administer R8's scheduled morning medications. R8's Resident Agreement (assisted living contract) dated May 22, 2023, under section 22 Statements Related to Public Assistance Programs noted, "whether the facility was enrolled with the commissioner of human services to provide customized living services under medical assistance waivers." R8's Resident Agreement (assisted living contract) dated May 22, 2023, did not include the following required information: - whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - 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; - 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; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; and	0 940		

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0 940	Continued From page 24 - 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. On July 18, 2023, at 2:34 p.m., director of regulatory compliance (DRC)-D stated the same contract was used for all residents. On July 18, 2023, at 3:48 p.m., chief operating officer (COO)-M stated the contract did not include the above noted content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is	01060		

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	30809	A. BUILDING: _____ B. WING _____	07/19/2023

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01060	Continued From page 25 expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative: and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R15). 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	01060		

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01060	Continued From page 26 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: R15 had begun receiving assisted living services at the facility December 21, 2021. R15's service plan dated June 1, 2023, indicated R15 received medication administration, bathing, transfers, housekeeping, and laundry. R15's Resident Notes included the following: -February 13, 2023, at 10:42 a.m., resident had a fall this morning around 4:00a [sic]. When writer (clinical nurse supervisor (CNS)-B) arrived at facility this AM (morning) she (R15) was complaining about extreme pain in her right hip/groin and being unable to bear weight on her right leg. Resident could perform ROM (range of motion) but not without pain present. Writer contact [sic] resident son and asked if he would like her to be sent into the ED (emergency department) for evaluation, son agreed. 911 was called and resident was transferred to ED by ambulance for further evaluation. -February 14, 2023, at 8:20 a.m., writer (CNS-B) received an updated [sic] from resident's son. Son stated the resident has a broken Pelvic Socket [sic], resident was transferred down to another hospital the night of February 13, 2023, for further evaluation and plan going further. -February 15, 2023, at 12:42 p.m., writer (CNS-B) spoke with resident son. Son stated resident will be transferred to rehab short term. -March 20, 2023, at 12:20 p.m., writer (CNS-B) spoke to rehab facility and rehab facility is looking at discharge the end of the month (March 2023).	01060		

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01060	Continued From page 27 R15's Resident Note dated February 20, 2023, (seven days after the emergency relocation) indicated emergency relocation was February 13, 2023, written by director of regulatory compliance (DRC)-D. The emergency relocation further indicated resident was relocated to an acute hospital, listed the hospitals name, reason for transfer due to a fall, and estimated length of stay two (2) weeks. R15's record lacked a written notice that contained all required content including: - contact information for the OOLTC and the Office of Ombudsman for Mental Health and Developmental Disabilities; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R15's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On July 18, 2023, at 2:45 p.m., DRC-D stated the emergency relocation did not include the above noted content. In addition, DRC-D stated the report (emergency relocation) was from so long ago it could not be pulled (found in the electronic resident record) and did not have a confirmation the notice had been sent to the OOLTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		

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01640	Continued From page 28	01640		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure service plans were updated for one of three residents (R14). 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	01640		

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01640	Continued From page 29 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R14's diagnoses included frontotemporal neurocognitive disorder (the result of damage to neurons in the frontal and temporal lobes of the brain with symptoms of unusual behavior, emotional problems, trouble communicating, and difficulty walking) dementia, insomnia, osteoarthritis, restlessness, and agitation. On July 18, 2023, at 7:54 a.m., the surveyor observed unlicensed personnel (ULP)-J provide wound care services to R14's right medial knee wound. R14's prescriber orders dated June 7, 2023, included an order to clean the right medial knee wound with wound cleaner and gauze, apply skin prep to surrounding skin, and cover with a foam dressing every three days and prn (as needed). R14's Assessment dated June 21, 2023, indicated R14 had a pressure injury to his right inner knee. R14's Treatment Recap Summary dated July 1, 2023, through July 17, 2023, indicated staff provided wound care services on July 4, 7, 11, and 14, 2023. R14's service plan dated April 18, 2023, noted foot care would be provided daily, but did not include wound care as ordered every three days. On July 18, 2023, director of regulatory compliance (DRC)-D stated R14's service plan had not been revised to include wound care	01640		

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01640	Continued From page 30 services. The licensee's Contents of Service Plans policy dated June 6, 2023, noted services plans were reviewed and revised as needed based upon on-going resident assessment. All residents would have an up-to-date service plan identifying services to be provided based on the assessment by the registered nurse and/or other licensed health professional. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
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 ensure four of four residents (R9, R10, R5, R7) medications were stored according to manufacturer's recommended temperatures and failed to ensure the medication refrigerators maintained an acceptable temperature. 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	01880		

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01880	Continued From page 31 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 July 17, 2023, at 11:16 a.m., the surveyor reviewed the medication refrigerator in the "Lakeside" unit with unlicensed personnel (ULP)-F. ULP-F stated the current temperature of the refrigerator was 40 degrees Fahrenheit (F). The refrigerator contained the following medications: - six Bisacodyl 10 milligram (mg) suppositories for R9 - six acetaminophen 650 mg suppositories for R9 - two Bisacodyl 10 mg suppositories for R10 - one unopened Lantus 100 units/milliliter (ml) insulin pen (a multiple dose pen shaped injector device for insulin administration) for R8 On July 17, 2023, at 11:57 a.m., the surveyor toured the facility with campus director (CD)-E including a review of the medication refrigerator in the "Gardenside" unit. CD-E stated the current temperature of the refrigerator was 32 degrees F. The refrigerator contained the following medications: - six acetaminophen 650 mg suppositories for R5 - one unopened Lantus 100 units/ml insulin pen for R2 - one unopened Novolog mix 100 units/ml insulin pen for R5 - on unopened bottle of latanoprost solution 0.005% for R15 On July 17, 2023, at 12:32 p.m., the medication refrigerator in the "Beachside" unit was reviewed with CD-E. CD-E stated the current temperature of the refrigerator was 40 degrees F. The	01880		

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01880	Continued From page 32 refrigerator contained the following medications: - one unopened bottle of latanoprost solution 0.005% for R6 - 12 Bisacodyl 10 mg suppositories for R7 - 12 acetaminophen 650 mg suppositories for R7 On July 17, 2023, at 12:35 p.m., CD-E stated she was unaware of the frequency the medication refrigerators were monitored. On July 17, 2023, at 12:54 p.m., clinical nurse supervisor (CNS)-B stated the medication refrigerator temperatures were monitored daily and recorded electronically. CNS-B stated the acceptable temperature range for the medication refrigerators was 36 to 46 degrees F. CNS-B stated Bisacodyl, and acetaminophen suppositories were stored in the medication refrigerators. The medication refrigerator temperature logs dated June 1, 2023, through July 17, 2023, indicated the following: - the temperature for the "Beachside" medication refrigerator had been recorded three times out of the 47 opportunities - the temperature for the "Gardenside" medication refrigerator had been recorded two times out of the 47 opportunities - the temperature for the "Lakeside" medication refrigerator had been recorded eight times out of the 47 opportunities On July 17, 2023, at 1:23 p.m., the medication refrigerator temperature logs dated June 1, 2023, to July 17, 2023, were reviewed with the director of regulatory compliance (DRC)-D. DRC-D stated the temperatures of the medication refrigerators had not been recorded daily as required.	01880		

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01880	Continued From page 33 On July 18, 2023, at 4:09 p.m., CNS-B stated she had confirmed Bisacodyl, and acetaminophen suppositories should be stored at room temperature and not in the refrigerator. The manufacturer's instructions for Bisacodyl suppository dated November 21, 2022, indicated the suppositories should be stored at room temperature 59 to 86 degrees F. The manufacturer's instructions for acetaminophen suppository dated November 2021, indicated the suppositories should be stored at 68 to 77 degrees F. The manufacturer's instructions for Lantus insulin pens dated May 2019, indicated unopened insulin pens should be stored in the refrigerator 36 to 46 degrees F. The manufacturer's instructions for Novolog mix pens dated February 2023, indicated unopened pens should be stored in the refrigerator 36 to 46 degrees F. The manufacturer's instructions for latanoprost eye drops dated, September 2020, indicated the unopened bottles should be stored in the refrigerator between 36 to 46 degrees F. The licensee's Storage of Medications policy dated August 1, 2021, noted medications would be handled and stored to acceptable standards. The registered nurse will provide education to the resident/resident's representative on proper storage of medications in the home including the need to be refrigerated, or stored in a cool dry area, and according to manufacturer's recommendations. This may include a	01880		

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01880	Continued From page 34 combination of the resident's room and the nursing office. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to monitor for expired medications in the licensee's resident medications for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on July 17, 2023, at 10:53 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication	01890		

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01890	Continued From page 35 management services to the residents at the facility. On July 17, 2023, at 12:01, the surveyor toured the facility with campus director (CD)-E including a review of the locked medication cart in the locked medication room on Gardenside. CD-E confirmed the following: -R2's nasal saline spray expired May 2023 On July 17, 2023, at 12:58 p.m., CNS-B stated nurses should be checking for expired medications, remove the medications, and destroy the medications if expired. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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 treatments	01960		

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01960	Continued From page 36 were administered as prescribed, or to document the reason they were not provided to meet the resident's needs for two of three residents (R8, R14) with treatments managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 17, 2023, at 11:05 a.m., clinical nurse supervisor (CNS)-B stated the facility provided treatment services to residents. R8 R8's diagnoses included vascular dementia without behavioral disturbance, diabetes, and hypertension (HTN-high blood pressure). R8's service plan dated June 28, 2023, indicated services included oxygen maintenance three times daily. R8's prescriber orders dated July 6, 2023, included an order for continuous oxygen administration 3 liters (L) per minute via nasal cannula (a thin flexible tube which on one end splits into two prongs that are placed in the nostrils and from which a mixture of air and oxygen flow). R8's Assessment dated June 28, 2023, indicated	01960		

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01960	Continued From page 37 R8 wore continuous oxygen 3L per minute via nasal cannula. R8's Resident Service Recap dated July 1, 2023, through July 18, 2023, indicated oxygen maintenance was being recorded three times per day (morning, afternoon, and overnight). On July 18, 2023, at 8:07 a.m., the surveyor observed unlicensed personnel (ULP)-K remove R8's oxygen after R8 got into the bathtub. ULP-K then preceded to give R8 a bath, assisted R8 out of the tub, assisted R8 with dressing, assisted R8 to ambulate onto the scale for a weight, and then R8 ambulated back to R8's room down the hall. At 8:48 a.m., ULP-K placed R8's oxygen back on in R8's room at 3L per minute via nasal cannula. On July 18, 2023, at 1:49 p.m., ULP-K stated R8's oxygen was removed after getting into the bathtub and was not put back on until R8 returned to R8's room. ULP-K stated normally R8's oxygen is off during this time since it is easier to not have on while completing the bath. On July 18, 2023, at 2:46 p.m., director of regulatory compliance (DRC)-D stated R8's prescriber order for oxygen is 3L per minute via nasal cannula and would not expect the oxygen to be off any longer than 10 minutes. On July 18, 2023, at 4:13 p.m., CNS-B stated it would be expected of staff to keep R8's oxygen on at all times. R14 R14's diagnoses included frontotemporal neurocognitive disorder (the result of damage to neurons in the frontal and temporal lobes of the brain with symptoms of unusual behavior,	01960		

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01960	Continued From page 38 emotional problems, trouble communicating, and difficulty walking) dementia, insomnia, osteoarthritis, restlessness, and agitation. R14's service plan dated April 18, 2023, had not been revised to include wound care service. R14's prescriber orders dated June 7, 2023, included an order to clean the right medial knee wound with wound cleaner and gauze, apply skin prep to surrounding skin, and cover with a foam dressing every three days and prn (as needed). R14's Assessment dated June 21, 2023, indicated R14 had a pressure injury to his right inner knee. On July 18, 2023, at 7:54 a.m., the surveyor observed ULP-J provide wound care services to R14's right medial knee wound. R14's Treatment Recap Summary dated July 1, 2023, through July 17, 2023, provided instructions for wound care to be completed on Tuesdays and Fridays. The Treatment Recap Summary indicated staff provided wound care services on July 4, 7, 11, and 14, 2023 (every three to four days). On July 18, 2023, at 2:55 p.m., registered nurse (RN)-N stated R14's wound care to his right medial knee had been completed twice a week on Tuesdays and Fridays and not every three days as ordered. The licensee's Medication, Treatment and Therapy Reminders policy dated August 1, 2021, indicated residents will receive treatments per registered nurse assessment and provider orders.	01960		

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01960	Continued From page 39 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide a complete facility hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect the memory care residents from harm. This has the potential to directly affect all memory care residents receiving assisted living services. 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	02040		

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02040	Continued From page 40 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 July 19, 2023, between 10:45 a.m. and 1:30 p.m., survey staff toured the facility with the maintenance director-I. On July 19, 2023, between 1:30 p.m. to 2:00 p.m., survey staff received the facility's hazard vulnerability assessment, undated, Hazard Vulnerability Assessment for Property/Grounds, with the written purpose " ...To note any possible hazards and mitigate through needed repairs, monitoring, or other methods" for review. On July 19, 2023, at approximately 2:30 p.m., document review and interview with the campus director (CD)-E, the director of regulatory compliance (DRC)-D, and the chief operating officer (COO)-M, indicated facility's hazard vulnerability assessment and mitigation plan was incomplete and lacked memory-care-specific hazards and mitigations in the plan to protect the memory care residents from harm. The finding was evident as the documentation provided for the review had a column for "follow-up/repairs/mitigation " completely blank throughout the documentation. Survey staff explained to the CD-E, DRC-D, and the COO-M that the facility's hazard vulnerability plan was based on an audit of the conditions and needed repairs of the building and property to be conducted annually, rather than a memory-care specific hazard risk and mitigation plan to protect the memory care residents from harm. On July 19, 2023, at approximately 2:30 p.m., the	02040		

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02040	Continued From page 41 CD-E, DRC-D, and COO-M confirmed and acknowledged the findings during the interview. Survey staff explained that all potential safety risks and/or vulnerabilities on and around the property including the appliances in the open commercial kitchen and serving kitchens in buildings A and B, elopement risks through door deactivation and windows throughout building A must be identified, assessed, and mitigated and be documented in the plan to protect the memory care residents from harm. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were appropriate based on the needs of residents who resided in the facility with regards to safely storing chemicals and sharp objects. This had the potential to affect all 37 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	02310		

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02310	Continued From page 42 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee held an assisted living with dementia care license. On July 17, 2023, at 10:49 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided services to residents with dementia and other related disorders. On July 17, 2023, from 11:36 a.m. through 1:10 p.m., the surveyor toured the entire campus with campus director (CD)-E. CD-E stated the campus consisted of two separate buildings and referred to each building as a cottage. Each building layout was one secured unit (unit which requires a key fob to enter and exit). Cottage A had two separate wings (Lakeside, Farmside) and Cottage B had two separate wings (Gardenside, Beachside). STORAGE OF CHEMICALS On July 17, 2023, at 11:41 a.m., the surveyor opened the unlocked door under the kitchen sink on Beachside. CD-E stated all residents have access to under each kitchen sink as the cabinets do not have locks. CD-E confirmed the cabinet contained OxiClean Carpet and Rug Stain remover, Ecos Pro floor cleaner, Heavy Duty Scrubbing Bubbles disinfectant cleaner, X-Force disinfectant, Easy Off oven cleaner, Cascade Original dishwasher tablets, and CoastWide Professional Stainless-Steel cleaner and polish.	02310		

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02310	Continued From page 43 On July 17, 2023, at 11:51 a.m., the surveyor opened the unlocked door under the kitchen sink on Gardenside. CD-E confirmed the cabinet contained Orange Glo wood furniture cleaner, X-Force disinfectant and Clorox Bleach wipes. On July 17, 2023, at 12:39 p.m., the surveyor opened the unlocked door under the kitchen sink on Lakeside. CD-E confirmed the cabinet contained Cascade Original dishwasher tablets, X-Force disinfectant and Purrell disinfectant. On July 17, 2023, at 12:45 p.m., the surveyor opened the unlocked door to room 128 on Farmside. CD-E stated maintenance was updating the unoccupied resident room. The room contained one gallon approximately half full of paint thinner and one gallon approximately ¾ full of Restor-A-Finish paint stain. On July 17, 2023, at 12:51 p.m., the surveyor opened the unlocked closet adjacent to the commons area on Farmside. CD-E confirmed the closet contained seven full bottles of Fresh 100 acid bowl cleaner. On July 17, 2023, at 1:02 p.m., the surveyor opened the unlocked drawers in the common area entry way on Lakeside. Licensed assisted living director (LALD)-A confirmed the drawers contained a full bottle of Raid Ant Baits, and Hotshot Kitchen bug killer. On July 17, 2023, at 1:02 p.m., LALD-A stated chemicals should be stored securely. The licensee's Hazardous Substances policy dated June 13, 2023, indicated chemicals should be stored per label information requirements.	02310		

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02310	Continued From page 44 The Safety Data Sheet for OxiClean Carpet and Rug stain remover dated August 9, 2018, indicated exposure may aggravate pre-existing eye, skin, or respiratory conditions. The Safety Data Sheet for Ecos Floor Cleaner dated October 9, 2016, indicated it may cause skin irritation, if contacted with eyes to rinse eyes with running water for several minutes and if swallowed drink plenty of water and call for a doctor immediately. The Safety Data Sheet for Scrubbing Bubbles dated March 16, 2020, indicated to avoid contact with skin, eyes, clothing, and inhaling contents can be harmful or fatal. The Safety Data Sheet for X-Force disinfecting dated April 10, 2020, indicated may cause eye irritation, and if ingested may be harmful. The Safety Data Sheet for Easy Off Heavy-Duty oven cleaner dated May 21, 2020, indicated if eye contact, inhalation, skin contact, or ingestion occurs to get medical attention immediately and contact the poison center. The Safety Data Sheet for Cascade ActionPacs Original dated May 27, 2022, indicated in ingested get medical attention immediately if symptoms occur. The Safety Data Sheet for Stainless Steel Cleaner and Maintainer dated October 27, 2020, indicated may be fatal if swallowed and enters airways. The Safety Data Sheet for Orange Glow wood polish and conditioner dated March 13, 2015, indicated can cause irritation to the nose, throat,	02310		

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02310	Continued From page 45 upper respiratory tract, skin, eyes, mouth, throat, and stomach. The Safety Data Sheet for Clorox Germicidal Wipes dated August 15, 2017, indicated can cause irritation to skin and eyes. The Safety Data Sheet for Purell surface disinfectant dated December 22, 2015, indicated if ingested to rinse mouth with water and obtain medical attention. The Safety Data Sheet for Restor-A-Finish dated August 20, 2014, indicated can be harmful if inhaled, can cause mild skin irritation, and causes series eye irritation. The Safety Data Sheet for Acid Bowl Cleaner dated July 23, 2015, indicated can cause serious eye and skin irritation. The Safety Data Sheet for Raid Ant and Cockroach killer dated March 25, 2015, indicated inhaling contents can be harmful or fatal. The Safety Data Sheet for Hot Shot Flying Insect Killer dated December 12, 2016, indicated harmful if swallowed. STORAGE OF SHARP OBJECTS On July 17, 2023, at 12:45 p.m., the surveyor opened the unlocked door to room 128 on Farmside. CD-E stated maintenance was updating this unoccupied resident room. A toolbox was sitting on top of a table in the room. On the top of the toolbox there were two pocketknives. CD-E stated residents would be able to access room 128. On July 17, 2023, at 12:51 p.m., the surveyor	02310		

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02310	Continued From page 46 opened the unlocked closet adjacent to the commons area on Farmside. Inside the closet contained a pair of scissors. The surveyor then opened the drawer on the cabinet next to closet. The drawer contained four large knitting needles. On July 17, 2023, at 1:00 p.m., LALD-A stated sharp objects should be locked or stored out of resident reach. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during	02410		

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02410	Continued From page 47 toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of one resident (R2) was treated with dignity and respect when unlicensed personnel (ULP)-J provided medication management services in a nonprivate area. 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: R2's diagnoses included diabetes, chronic kidney disease, hypertension (HTN-high blood pressure), cerebral vascular accident (CVA-stroke) and anxiety. R2's service plan dated May 25, 2022, indicated R2 received services to include medication administration four times daily. R2's Individualized Medication Management Plan dated July 17, 2023, indicated R2 needed assistance with administering medications and medication management tasks delegated to ULP included administration of topical medications. R2's prescriber orders dated September 29, 2022, included an order for lidocaine cream 4% to	02410		

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02410	Continued From page 48 be applied to painful joints three times daily. Place on left and right hips, back of neck, left shoulder and desired areas. On July 18, 2023, at 7:26 a.m., ULP-J escorted R2 into the locked medication room. The medication room had an unshaded window facing out into the open kitchen/common area where residents were often seen walking and seated. ULP-J obtained from the medication cart R2's scheduled lidocaine cream 4%; checked R2's electronic medication administration record (MAR); and applied gloves. R2 while seated removed her shirt and ULP-J with gloved hands applied the lidocaine cream with a roll top applicator to R2's thumbs, shoulders, and back of her neck. R2 stood up and faced the open/uncovered window exposing her unclothed upper torso and breasts. R2 then dropped her pants and brief down below her knees and stood facing the open/uncovered window naked from the neck down to below her knees. ULP-J applied the lidocaine cream 4% to R2's back, hips, and thighs upon R2's request. During this time the surveyor observed employees, R3 and R16 to walk by the uncovered medication room window and had the potential to visualize R2's unclothed body. On July 18, 2023, at 7:40 p.m., directly following the above noted observation, ULP-J stated the window in the medication room did not have a shade or curtain that could be pulled, nor was the window tinted so one could only see out and not into the medication room. ULP-J stated R2 was exposed when applying the lidocaine cream and other residents, visitors or employees could have visualized her unclothed body through the medication room window. ULP-J stated R2 was usually brought into the medication room to have	02410		

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02410	Continued From page 49 her blood glucose checked and lidocaine cream applied. On July 18, 2023, at 8:49 a.m., maintenance director (MD)-I measured the medication room window with the surveyor present. MD-I stated the measurements of the window were 28 ½ inches wide and 35 inches tall. On July 18, 2023, at 2:41 p.m., director of regulatory compliance (DRC)-D stated to promote privacy R2's lidocaine medication should be applied in the resident's room and not in the medication room with the uncovered window. The licensee's undated Medication Administration - Routes procedure directed for staff when applying a topical medication to ensure resident's privacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		
03000 SS=D	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:	03000		

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03000	Continued From page 50 (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: Based on observation, interview, and record	03000		

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03000	Continued From page 51 review, the licensee failed to submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R3) who eloped and had incidents of resident-to-resident altercations. 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 held a current assisted living with dementia care (ALDC) license. On July 17, 2023, at 11:20 a.m., the surveyor asked clinical nurse supervisor (CNS)-B to provide the MAARC and incident reports for the last six months. The Incident Summary log dated January 31, 2023, through July 17, 2023, indicated R3 eloped on May 3, 2023, at 2:30 p.m., sustained a fall on January 31, 2023, and an "other injury" on June 25, 2023. No MAARC reports were provided. R3's diagnoses included vascular dementia with behavior disturbance, chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing) and hypothyroidism. R3's service plan dated October 11, 2022, indicated the resident received services to include medication administration, fall prevention/safety checks, vital sign monitoring, assistance with	03000		

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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 52 bathing, morning/evening cares, housekeeping, and laundry. R3's Clinical Update Assessment dated May 11, 2023, indicated R3 needed a locked memory care unit, required supervision from trained staff, assistance with medication administrations, and activities of daily living (ADL). The section under "Elopement History" was blank. R3 was identified as having four falls in the last three months with the last fall being on January 31, 2023. R3 was to have safety checks completed every two hours during the day and one hour at night. Staff were directed to check the security on doors, gates, and alarms. R3 was identified as having a balance problem with standing, and walking and was to always have his walker with him during transfers and ambulation. R3 was identified as an elopement/wandering risk. R3 had a history of wandering at previous facility and staff were to be aware of R3's location. R3's pattern of wandering was identified as wanders inside, occasionally into other's rooms, but does not leave the building. Staff were directed to intervene if R3 was found in other resident's rooms, and escort him back to the common areas. Staff were to always know R3's whereabouts. R3's Clinical Update Assessment dated July 14, 2023, indicated the same information above, however, indicated R3 had an elopement attempt on May 3, 2023, staff were to be aware of resident's location and had one fall in the last three months. R3's individualized abuse prevention plan (which was incorporated into R3's Clinical Assessments noted above) indicated R3 was at risk to be abused by others and was at risk to abuse other vulnerable adults. It was noted the facility's	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30809	A. BUILDING: _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PSC OF ISANTI LLC	706 6TH AVENUE NE ISANTI, MN 55040

(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 53 environment was designed to minimize stress that could cause agitation and the staff had been professionally trained to deal with dementia-influenced behavior. The staff would attempt to diffuse and redirect aggressive behaviors. The facility had policies in place to protect residents from aggressive behaviors in most instances. In addition, it was noted all staff at the facility were mandated reports of suspected abuse. R3's Elopement report dated May 4, 2023, indicated resident was outside of the enclosed fenced area wandering on May 3, 2023. The last safety check was done at 2:15 p.m. Staff coming onto their shift found R3 around 2:30 p.m., wandering with his walker in the unsecure parking lot of the facility. Staff were able to redirect him back into the building with no concerns. During the investigation it was found the outside fence doors lock had failed and R3 was able to leave through the gate with no resistance, maintenance was notified and placed a bike lock onto the fence door until the fence company could come and fix the lock issue. It was noted in the "Other Info?" section that R3 was completely unaware of what he was doing at the time. R3 does not attempt to elope, likes to check all the doors in the building due to curiosity but never tries to leave. On July 18, 2023, at 11:42 a.m., director of regulatory compliance (DRC)-D and maintenance director (MD)-I showed the surveyor where R3 had exited the secure grounds of the facility on May 3, 2023. MD-I stated R3 had exited the outside patio area through a gate in which the magnetic lock was malfunctioning making the gate unsecure. DRC-D stated it appeared R3 had lifted the latch on the gate and was able to exit the gate into the adjacent parking lot.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30809	A. BUILDING: _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PSC OF ISANTI LLC	706 6TH AVENUE NE ISANTI, MN 55040

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03000	Continued From page 54 Observed directly to the right of the parking lot was an embankment which went down into a swampy area. DRC-D stated an elopement was never "good". No MAARC report was provided for this incident of elopement. R3's Fall report dated February 2, 2023, noted R3 was standing in the "Beachside" living room when another resident (R16) came up to R3 and pushed him, causing R3 to fall onto his bottom/side. It was also documented there was no witnesses to the fall; no injuries; and there was a pattern noted as R16 has "it out for this resident [R3] pushing him [R3] and causing him [R3] to fall". No MAARC report was provided for this incident. R3's Other Injury report dated June 25, 2023, noted R3 went into another resident's room. The staff heard a noise coming from the other resident's room. R3 was found to have a scratch on his back/neck area. "It was apparent that other resident became aggressive with [name of R3]." No MAARC report was provided for this incident. On July 18, 2023, at 3:01 p.m., campus director (CD)-E stated a MAARC report should be filed within 24 hours of knowledge of an event that would be any suspected abuse or maltreatment. Chief operating officer (COO)-M stated a MAARC report was only filed when a resident needed to seek medical attention. On July 18, 2023, at 3:03 p.m., COO-M stated no MAARC reports had been filed involving R3.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30809	A. BUILDING: _____ B. WING _____	07/19/2023

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03000	Continued From page 55 On July 18, 2023, at 3:55 p.m., CNS-B stated a MAARC report should be completed within 24 hours of an incident resulting in an injury. CNS-B stated she would also consider any elopement a reportable event that should generate a MAARC report. CNS-B reviewed R3's three incidents noted above. CNS-B stated she was unsure why R3's elopement incident on May 3, 2023, wasn't reported to MAARC. CNS-B stated on review of the above noted incidents involving R3, CNS-B stated "all three of these incidents probably should have been reported" to MAARC. The licensee's Vulnerable Adult Maltreatment Policy dated June 1, 2023, noted the organization would create an environment and process to identify, prevent, and mitigate maltreatment of vulnerable adults. Any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately to their supervisor, a nurse, or the LALD (licensed assisted living director) and that person will complete an incident report. If the incident appears to be suspected of abuse, neglect, or financial exploitation, LALD or CNS will immediately make a report to the CEP (common entry point). "Immediately means as soon as possible, but no longer than 24 hours from the time the LALD or CNS received initial knowledge that the incident occurred. If it is unclear based whether maltreatment has occurred, and investigation into the incident will begin immediately. If within the 24 hours following the initial incident report, it is still unclear whether reportable maltreatment has occurred, a report will be made to the CEP. All staff are educated on report of suspected maltreatment and their obligation to report as mandated reporters. Education includes internal reporting	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30809	A. BUILDING: _____ B. WING _____	07/19/2023

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PSC OF ISANTI LLC	706 6TH AVENUE NE ISANTI, MN 55040

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03000	Continued From page 56 process and the choice to report directly to the CEP. The licensee's Missing Resident Policy dated June 13, 2023, in the event a resident elopes from the facility and/or is missing it was identified in the policy within 24 hours of the incident, report to MAARC. The licensee's Wandering and Egress Prevention in ALDC policy, dated January 31, 2023, noted it was the policy of the facility to assure safe wandering and safeguard against egress/elopement. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *07/19/23*
Time: 10:30:25
Report: 1029231169

Food and Beverage Establishment Inspection Report

Location:

Psc Of Isanti Llc
706 6th Avenue Ne
Isanti, MN55040
Isanti County, 30

Establishment Info:

ID #: 0038854
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7634444626
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

QUATERNARY AMMONIUM: = 200 PPM at Degrees Fahrenheit
Location: DISPENSER
Violation Issued: No

HOT WATER: = at 165 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: SLICED CHEESE
Temperature: 40 Degrees Fahrenheit - Location: 2-DOOR MAX COLD COOLER
Violation Issued: No

Process/Item: MARGARINE
Temperature: 40 Degrees Fahrenheit - Location: 2-DOOR MAX COLD COOLER
Violation Issued: No

Process/Item: MILK
Temperature: 39 Degrees Fahrenheit - Location: BEACH SIDE COOLER
Violation Issued: No

Process/Item: POTATO SALAD
Temperature: 39 Degrees Fahrenheit - Location: LAKE SIDE COOLER 1
Violation Issued: No

Process/Item: BUTTER
Temperature: 39 Degrees Fahrenheit - Location: LAKE SIDE COOLER 2
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

Conducted inspection intermittently in the presence of Rikki Hari, Kitchen Services, and Sara Michals, Campus Director.

Topics discussed with Rikki and/or Sara included employee illness reporting and exclusion procedures, vomit/fecal matter cleanup, sanitizing, highly susceptible populations, date marking effectively, common contagious foodborne illness pathogens (e.g., salmonella, shigella, Shiga toxin-producing E. coli, hepatitis A virus, and norovirus), hygienic practices (e.g., handwashing), and general food safety practices (e.g., holding temperatures at or below 41°F and 135°F or above for TCS foods). Rikki's CFPM certificate was expired (3/22/23) but she indicated that she completed the renewal course prior to the expiration date and had just recently mailed her CFPM renewal information to obtain a new certificate, thereby utilizing the 6-month (9/22/23) renewal grace period.

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 1029231169 of 07/19/23.

Certified Food Protection Manager: Rikki Rachelle Hari

Certification Number: FM56596 Expires: 03/22/23

Signed: _____

Rikki Hari
Kitchen Services

Signed: Trevor L McCliment

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029231169

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 07/19/23
Time In 10:30:25
Time Out

Psc Of Isanti Llc	Address: 706 6th Avenue Ne	City/State: Isanti, MN	Zip Code: 55040	Telephone: 7634444626
License/Permit #: 0038854	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	(IN) OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	(IN) OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	(IN) OUT N/O	Hands clean & properly washed		
9	IN OUT N/A (N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	(IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A (N/O)	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	IN OUT N/A (N/O)	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	(IN) OUT N/A N/O	Proper date marking & disposition		
24	IN OUT (N/A) N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)	Food additives: approved & properly used		
28	(IN) OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 07/21/23

Inspector (Signature) Trevor L McDermott