Electronically Delivered

April 2, 2025

Licensee
Orchard Hill Senior Living
1223 Karl Drive
New Ulm, MN 56073

RE: Project Number(s) SL23169016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 26, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23169	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD HILL SENIOR LIVING	1223 KARL DRIVE NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL23169016 On February 24, 2025, through February 26, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 51 residents; 35 receiving services under the Assisted Living Facility 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 Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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

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0 470	Continued From page 2 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 24, 2025, at 11:24 a.m. the surveyor toured the facility with assisted living director in residence (ALDIR)-A. There was no evidence of a daily posted staff schedule with the required content. ALDIR-A stated they had a whiteboard in the hallway with magnets to indicate who was working each shift; however, it did not include the hours of each shift nor how many staff would be working on each individual shift. The licensee's 4.06 Staffing & Scheduling policy dated August 23, 2021, indicated: 3. The clinical nurse supervisor will develop a 24-hour daily staffing schedule that will identify: a. direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked, and b. the direct-care staff member's resident assignments or work location. 4. The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		

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0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts	0 480		

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0 480	Continued From page 4 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 24, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 5 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a menu prepared in advance included all meals and snacks. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 485		

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0 485	Continued From page 6 the residents). The findings include: The licensee's menu lacked inclusion of the breakfast meal and snacks. During the facility tour on February 24, 2025, at 11:24 a.m., assisted living director in residence (ALDIR)-A stated the menu posted for the week of February 24, 2025 - March 2, 2025, did not include breakfast or snacks. ALDIR-A stated breakfast options were usually the same every day, and residents were aware of what the options were; snacks were always available. The licensee's 12.01 Food Service & Menu Planning policy dated August 1, 2021, indicated: 1. Menus will be prepared at least one (1) week in advance and made available to all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.	0 510		

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0 510	Continued From page 7 (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related disposal of soiled dressings during wound care for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's current unsigned, Service Plan printed February 25, 2025, indicated R3 received assistance with wound care. On February 26, 2025, at 10:12 a.m., the surveyor observed unlicensed personnel (ULP)-E providing wound care for R3 in his apartment. R3 was seated in his recliner in the living room with ace wraps on his lower legs bilaterally. ULP-E cleansed hands, donned clean gloves and then removed R3's ace wraps. ULP-E rolled up the ace wraps and placed on the carpeted floor next to the recliner. ULP-E removed their gloves turning them inside	0 510		

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0 510	Continued From page 8 out and placing on the carpeted floor beside her, cleansed hands, donned clean gloves, and removed the Telfa dressings from R3's legs (two on right leg and two on left leg) and set them on the floor with the side facing away from the resident's body on the floor. ULP-E removed their gloves turning them inside out and placing on the floor beside her, cleansed hands, donned clean gloves, then applied spray-on skin cleanser to the wounds and patted dry with clean gauze. ULP-E removed their gloves by turning them inside out and placing them on the floor beside her, cleansed hands, donned clean gloves, then applied antibiotic ointment to the wounds using a different finger for each application. ULP-E then removed their gloves turning inside out and placing on the floor beside her, cleansed hands, donned clean gloves, then applied Telfa dressing to the wounds and wrapped with clean ace wraps to legs bilaterally. ULP-E then picked up R3's used ace wraps from the floor and placed in a laundry basket stating the night shift hand washes them and hangs them to dry. ULP-E then picked up the soiled dressings and gloves off the floor, threw them into a trash receptacle in the resident's living room, doffed gloves and threw them away, cleansed hands, then asked R3 if there was anything else he needed before exiting the apartment. On February 25, 2025, at 10:29 a.m., clinical nurse supervisor (CNS)-B stated when providing wound care, CNS-B would expect staff to remove the used Telfa dressings and keep in hand while removing gloves (turning inside out) so the dressings were contained, then dispose of them in garbage bag. CNS-B further stated this was how the staff were trained. No further information provided.	0 510		

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0 510	Continued From page 9 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above.	0 620		

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0 620	Continued From page 10 (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	0 620		

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0 620	Continued From page 11 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 February 24, 2025, at 10:31 a.m., clinical nurse supervisor (CNS)-A stated a couple months ago one of their residents walked away from the facility to another assisted living a couple blocks away. That facility called to let them know the resident was there. CNS-A stated implementing hourly checks until the family found a memory care facility to transfer the resident to. R4's diagnoses included memory loss and muscle weakness. R4's 90-day assessment dated December 34, 2024, indicated R5 was confused and anxious at times. Staff to direct/remind resident and cue/calm as needed. The assessment further indicated R4 had a tracker (a GPS (global positioning system) device used to help track and send your ward's precise location in real time) on. R4's progress note by CNS-A dated January 6, 2025, at 7:49 a.m., indicated: Writer received a phone call this morning from the director of [name of assisted living facility in town] that resident was at their building. She told them she was looking for her church. Writer called the building, and they went and got the resident and brought her home. Writer called family and we talked about that it was time for them to look for a memory care for resident. Family was in agreement and stated they will start looking for somewhere else for her to live. Until this happens we will start more frequent checks on resident to keep her	0 620		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD HILL SENIOR LIVING	1223 KARL DRIVE NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 12 safe. On February 24, 2025, at 1:10 p.m., CNS-A stated she had not filed a MAARC report related to R4's elopement as the resident didn't get hurt. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated August 1, 2021, indicated: 5. f. If the Assisted Living Director or Clinical Nurse Supervisor confirms the suspicion of maltreatment, they will contact the Minnesota Adult Abuse Reporting Center (MAARC). Such report must be made no later than 24 hours after the maltreatment was first suspected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of	0 660		

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0 660	Continued From page 13 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) to include an annual facility TB risk assessment. In addition, the facility failed to conduct a TB symptom screen for one of two unlicensed personnel (ULP-F), and documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of two employees (ULP-E, ULP-F). This 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: TB risk assessment During the entrance conference on February 24, 2025, at 10:31 a.m. with assisted living director in residence (ALDIR)-A and clinical nurse supervisor (CNS)-B, the surveyor requested to review the facility's TB risk assessment. On February 26, 2025, at 10:54 a.m., ALDIR-A	0 660		

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0 660	Continued From page 14 provided the surveyor with a copy of a blank TB Facility Risk Assessment. The surveyor requested a completed risk assessment be provided. ALDIR-A checked with CNS-B who was unable to find evidence a TB risk assessment had been completed. ULP-F ULP-F was hired August 21, 2024, to provide direct care services. ULP-F's employee file did not include evidence a TB symptom screen had been completed upon hire or any kind of TB testing. ULP-E ULP-E was hired May 21, 2018, to provide direct care services. On February 26, 2025, at 10:12 a.m., the surveyor observed ULP-E providing wound treatment for R3. ULP-E's employee file included a TB Symptom Screen dated February 20, 2024, and a one-step TST administered March 7, 2023, and read on March 10, 2023. There was no evidence a second-step TST had been completed. On February 26, 2025, at 2:48 p.m., CNS-B stated ULP-F had not completed a TB symptom screen or TB testing as required. CNS-B further stated ULP-E only received a one-step TST as she thought that was all that was required. The MN Department of Health Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Setting Licensed	0 660		

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0 660	Continued From page 15 by MDH updated June 2024, indicated: Settings should perform a facility risk assessment on an annual basis. The worksheet further indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes: 1. Assessing for current symptoms of active TB disease. 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. The licensee's 8.16 Tuberculosis Screening policy dated August 27, 2021, indicated: Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs (health care workers). 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 16 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required contents. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 680		

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0 680	Continued From page 17 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on February 24, 2025, at 10:31 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided and later reviewed by the surveyor. The licensee's plan lacked an all-hazards vulnerability assessment in addition to the following required content: - a description of the population served by the licensee; - process for emergency preparedness (EP) collaboration with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situations; - development of policies/procedures to address: - evacuation plan; - shelter in place; - the medical record documentation system to preserve resident information; - use of volunteers; - emergency staff strategies; and - the facility's role in providing care and treatment at alternative sites. - a communication plan that included: - primary and alternative means for communicating with facility staff, or federal, state, regional and local - policies and procedures to address role of facility under a waiver declared by the Secretary	0 680		

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0 680	Continued From page 18 in accordance with section 1135 of the Act -emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -a method of sharing information from the emergency plan with residents and their families. - EP testing/annual testing requirements. On February 26, 2025, at 12:41 a.m., assisted living director in residence (ALDIR)-A stated the above content was not included in the emergency preparedness plan. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, indicated the licensee's emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number;	0 730		

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0 730	Continued From page 19 (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this	0 730		

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0 730	Continued From page 20 chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included the required documentation related to hospitalization for one of one resident (R3), and failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 R3's diagnoses included congestive heart failure (CHF). R3's current unsigned, Service Plan printed February 25, 2025, indicated R3 received services including medication administration, daily weight and blood pressure monitoring, wound care, shower assistance, housekeeping, and laundry. R3's provider note dated December 4, 2024, indicated R3 was hospitalized November 15, 2024 - November 20, 2024, with CHF exacerbation. R3 discharged from the hospital to	0 730		

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0 730	Continued From page 21 a skilled nursing facility. R3 was seen by the provider at the skilled nursing facility for evaluation for discharge. R3's progress note dated December 11, 2024, indicated the resident returned from the nursing home today. There were no progress notes prior to this date indicating R3 had been hospitalized, what led to the hospitalization, and subsequently admitted to a skilled nursing facility prior to returning to the licensee. On February 26, 2025, at 10:06 a.m., clinical nurse supervisor (CNS)-B stated she doesn't usually document when a resident is hospitalized or circumstances surrounding why and was unaware of the requirement. R4 R4 was admitted to the licensee on July 1, 2021, with diagnoses including memory loss, muscle weakness, and hypertension. R4 discharged from the facility on February 11, 2025. R4's Service Plan dated July 31, 2021, indicated the resident received services including medication administration, shower assistance, housekeeping, laundry, meals, and well being checks. R4's record lacked a discharge summary to include: - diagnoses; - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline	0 730		

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0 730	Continued From page 22 and current mental, behavioral, and functional status. On February 25, 2025, at 9:25 a.m., CNS-B stated she had not completed a discharge summary for R4 until February 24, 2025, when the surveyor requested it. After reviewing the statute, CNS-B stated the discharge summary she completed did not include all required content other than diagnoses and allergies. The licensee's 2.38 Resident Record - Information and Content policy dated August 1, 2021, indicated: Resident Records must include: 9. Documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional. 10. Documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional. 14. A discharge summary, including service termination notice and related documentation, when applicable. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code:	0 780		

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0 780	Continued From page 23 (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 that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	0 780		

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0 780	Continued From page 24 The findings include: During facility tour on February 25, 2025, from 9:36 a.m. through 10:40 a.m., with director of maintenance (DM)-D, the surveyor observed the following: Resident rooms had single-station smoke alarms installed inside the sleeping rooms and outside in the immediate vicinity of the sleeping rooms. During the tour DM-D tested the smoke alarms. Resident rooms 215, 217 and 222 had smoke alarms that were not interconnected so that activation of one alarm activates all alarms within the resident room. All resident units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. DM-D verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=D	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 facility tour on February 25, 2025, from 9:36 a.m. through 10:40 a.m., with director of maintenance (DM)-D, the surveyor observed that the two fire extinguishers located in the garage had a tag indicating the last annual service was performed in September 2023 and expired in September 2024. Documentation is required to demonstrate fire extinguishers have been annually replaced with a new extinguisher or serviced annually by a certified technician. During the tour DM-D stated that the garage extinguishers must have been missed when the company serviced the extinguishers in the facility. DM-D stated they understood the requirement and would have the garage extinguishers serviced.	0 790		

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0 790	Continued From page 26 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff 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) Staff 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD HILL SENIOR LIVING	1223 KARL DRIVE NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 27 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content and failed to conduct the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 25, 2025, at 10:51 a.m., assisted living director in residency (ALDIR)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The FSEP did not include an evacuation map with a floor plan accurate to the building layout that showed the location and number of resident sleeping rooms. TRAINING Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire and twice per year as evident by not providing documentation of training offered or training scheduled for a future date. ALDIR-A stated they	0 810		

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0 810	Continued From page 28 try to provide training during fire drills but could not provide documentation of employee training. Record review indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation of training offered or training scheduled for a future date. ALDIR-A stated that no resident training had been conducted in the past year. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. ALDIR-A provided documentation indicating drills had been performed February 20, 2024, and October 15, 2024. ALDIR-A stated these were the only drills conducted in 2024. During an interview on February 25, 2025, at 11:20 a.m., ALDIR-A stated they understood the areas of the plan that needed to be updated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	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,	01060		

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01060	Continued From page 29 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 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 a written notice with the required content for an emergency relocation and	01060		

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01060	Continued From page 30 failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation when the resident had not returned to the facility within four days for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 R1's diagnoses included type II diabetes mellitus with diabetic neuropathy, chronic kidney disease, and hypertension. R1's current unsigned Service Plan printed February 25, 2025, indicated R1 received services including medication administration, medication set-up, blood glucose checks, level two special diet, housekeeping, and laundry. R1's progress notes dated November 28, 2024, indicated R1 had fallen in his apartment. Family transported him to the emergency department due to weakness and low blood pressure. R1 was diagnosed with aspiration pneumonia per hospital and will be going for rehabilitation. R1 returned to the licensee on January 27, 2025. R3 R3's diagnoses included congestive heart failure (CHF).	01060		

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01060	Continued From page 31 R3's current unsigned Service Plan printed February 25, 2025, indicated R3 received services including medication administration, daily weight and blood pressure monitoring, wound care, shower assistance, housekeeping, and laundry. R3's provider note dated December 4, 2024, indicated R3 was hospitalized November 15, 2024 - November 20, 2024, with CHF exacerbation. R3 discharged from the hospital to a skilled nursing facility. R3 was seen by the provider at the skilled nursing facility for evaluation for discharge. R3's progress notes indicated the resident returned to the licensee on December 11, 2024. R1 and R3's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked evidence of notification to OOLTC when they were hospitalized more than four days.	01060		

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01060	Continued From page 32 On February 25, 2025, at 9:25 a.m., clinical nurse supervisor (CNS)-B, stated the licensee did not provide an emergency transfer notice to resident, legal representative, and designated representative when any residents were hospitalized, nor were they notifying the ombudsman when the relocation exceeded four days. CNS-B stated being unaware of the requirement. The licensee's 1.19 Emergency Relocation policy dated August 1, 2021, indicated: 1. In the event of an emergency relocation, the licensee will provide a written notice that contains, at a minimum: a. The reason for the relocation b. The name and contact information for the location to which the resident has been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care d. If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. 3. The facility will provide contact information for the agency to which the resident may submit an appeal. 4. The notice required will be delivered as soon as practicable to: a. The resident, legal representative, and designated representative b. For residents who receive home and community-based waiver services, the resident's case manager, and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has	01060		

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01060	Continued From page 33 not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01640 SS=F	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 interview and record review, the licensee failed to ensure a written service plan was revised and signed by the resident to reflect the current services provided for three of three	01640		

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01640	Continued From page 34 residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on November 9, 2024, with diagnoses including type II diabetes mellitus with diabetic neuropathy, chronic kidney disease, and hypertension. R1's current unsigned Service Plan printed February 25, 2025, indicated R1 received services including medication administration, medication set-up, blood glucose checks, level two special diet, housekeeping, and laundry. On February 25, 2025, at 11:27 a.m., the surveyor observed unlicensed personnel (ULP)-G checking R1's blood glucose level and administering insulin. R2 R2 was admitted on July 17, 2020, with diagnoses including hypertension, type II diabetes, edema, and depression. R2's current unsigned Service Plan printed February 25, 2025, indicated R2 received services including medication administration, meals, well being checks, housekeeping, and laundry.	01640		

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01640	Continued From page 35 R3 R3 was admitted on October 2, 2023, with diagnoses including congestive heart failure (CHF). R3's current unsigned Service Plan printed February 25, 2025, indicated R3 received services including medication administration, daily weight and blood pressure monitoring, wound care, shower assistance, housekeeping, and laundry. On February 26, 2025, at 10:12 a.m. the surveyor observed ULP-E performing wound care to R3's lower legs. On February 25, 2025, at 10:43 a.m., assisted living director in residence (ALDIR)-A stated they only had residents sign their initial service plan and did not have the residents resign a new service plan when it was revised. ALDIR-A stated R1 and R3's services had changed since admission. R2's services had not changed, although her signed service plan from admission, dated July 13, 2020, was reflective of the previous home care statutes. The licensee's 6.10 Service Plan Modifications policy dated August 26, 2021, indicated: If the service plan needs to be modified due to a change in a prescriber's order or a change in the resident's needs, the Service Plan Modification form will be completed; this form includes: Describe changes in service and whether the service is added (new), changed, or discontinued Frequency of new service or if service terminated Identification of the staff who will perform the service Schedule and methods of monitoring staff	01640		

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01640	Continued From page 36 Fee for the service Date/Signature of RN (registered nurse) making changes Date/signature of resident or the resident's representative each time a modification is made. The signature may be obtained by mail or fax if an agreement was reached in person or by telephone. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01770		

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01770	Continued From page 37 The findings include: During the entrance conference on February 24, 2025, at 10:31 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents, including medication setup. R1's current unsigned Service Plan printed February 25, 2025, indicated R1 received services including medication set-up. R1's prescriber orders signed January 22, 2025, included two vitamin supplements, one calcium supplement, one prostate medication, one thyroid, one cholesterol, two cardiac, and one for diabetes. On February 25, 2025, at 12:49 p.m., R1 stated the nurse sets up his oral medications weekly into a pill box and then he takes them independently in his apartment. R1's spouse stated she used to do this for R1, but now the nurse does. R1's record did not include evidence of medication set-up by the nurse. On February 25, 2025, at 2:25 p.m., clinical nurse supervisor (CNS)-B stated although they have a system for documenting when the nurse sets up medications for a resident, this had not been completed for R1. CNS-B further stated this was a fairly new service for R1 and wasn't sure why the licensed practical nurse hadn't documented it. The licensee's 7.09 Medication Management-Dosage Box Setup policy dated August 26, 2021, indicated: 4. The licensed nurse sets up medication	01770		

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01770	Continued From page 38 bi-weekly/weekly into the dosage boxes. 5. When the licensed nurse has completed setting up the medications into the dosage box, the set-up is documented on the MAR (medication administration record). No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent	01940		

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01940	Continued From page 39 possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 February 24, 2025, at 10:31 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to residents, including assistance with simple wound care. R3's current unsigned Service Plan printed February 25, 2025, indicated R3 received services including wound care. R3's provider order signed October 30, 2024, indicated: Ace wraps bilateral legs in AM and place Telfa pads on sores. Unwrap before bed. Call me if sores get worse.	01940		

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01940	Continued From page 40 On February 26, 2025, at 10:12 a.m., the surveyor observed unlicensed personnel (ULP)-E performing wound care to R3's lower legs. R1's record lacked a treatment management plan to include the following required content: - procedures for notifying a registered nurse (RN) when a problem arose with treatments or therapy services. On February 25, 2025, at 9:25 a.m., CNS-B reviewed R1's treatment plan and stated it did not include direction to staff of when to notify a nurse when problems arose with the R3's lower leg wounds. The licensees 7.05 Treatments & Therapy Management Plan policy dated August 26, 2021, indicated: 1. The licensee will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment and/or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23169	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD HILL SENIOR LIVING	1223 KARL DRIVE NEW ULM, MN 56073

(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
01950	Continued From page 41 perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff notified the registered nurse (RN) of increased weight change for one of one resident (R3), and failed to ensure two of two unlicensed personnel (ULP-E, ULP-F) demonstrated competency for wound care to a RN. 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: R3	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23169	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD HILL SENIOR LIVING	1223 KARL DRIVE NEW ULM, MN 56073

(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
01950	Continued From page 42 R3's current unsigned Service Plan printed February 25, 2025, indicated R3 received services including daily weights. R3's provider orders dated December 4, 2024, included: Daily weight. Call physician if weight increases by two pounds (lbs) in 24 hours or five lbs in seven days from admission weight in the morning. R3's Service Recap Summary dated February 2025, included daily weight at 8:00 a.m. On February 25, 2025, at 9:25 a.m. clinical nurse supervisor (CNS)-B brought up R3's electronic record on the computer for the surveyor to visualize. CNS-B brought up the note section under the daily weights that directed staff when to contact the nurse. The note indicated to contact the nurse if weight greater than 152 lbs. Review of R3's weights over the last 30 days indicated a range of 178-182 lbs. CNS-B stated the direction to staff of 152 lbs was inaccurate as that reflected R3's weight when first admitted to the licensee in 2023. CNS-B further stated staff had not contacted her about the discrepancy with the weight being well over 152 lbs. ULP-E ULP-E was hired on May 21, 2018, to provide direct care services to residents. On February 26, 2025, at 10:12 a.m., the surveyor observed unlicensed personnel (ULP)-E performing wound care and applying ace wraps to R3's lower legs. ULP-F ULP-F was hired on August 21, 2024, to provide direct care services to the residents.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23169	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD HILL SENIOR LIVING	1223 KARL DRIVE NEW ULM, MN 56073

(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
01950	Continued From page 43 ULP-E and ULP-F's employee record lacked competencies for wound care and ace wrap application. On February 26, 2025, at 4:10 p.m., CNS-B trained staff on wound care and ace wrap application when the need came up; however, CNS-B did not complete a signed competency for either employee. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated: 7. Additional nursing tasks that are frequently delegated to unlicensed personnel that would require training and competency testing by a RN include: Ace bandage application Wound care procedures 11. A copy of all education, training, and competency testing shall be kept in each employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23169	A. BUILDING: _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD HILL SENIOR LIVING	1223 KARL DRIVE NEW ULM, MN 56073

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01960	Continued From page 44 ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment orders were accurately transcribed for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's current unsigned Service Plan printed February 25, 2025, indicated R3 received services including daily weights. R3's provider orders dated December 4, 2024, included: Daily weight. Call physician if weight increases by two pounds (lbs) in 24 hours or five lbs in seven days from admission weight in the morning. R3's Service Recap Summary dated February 2025, included daily weight at 8:00 a.m. On February 25, 2025, at 9:25 a.m., clinical nurse supervisor (CNS)-B brought up R3's electronic record on the computer for the	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD HILL SENIOR LIVING	1223 KARL DRIVE NEW ULM, MN 56073

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01960	Continued From page 45 surveyor to visualize. CNS-B brought up the note section under the daily weights that directed staff when to contact the nurse. The note indicated to contact the nurse if weight greater than 152 lbs. Review of R3's weights over the last 30 days indicated a range of 178-182 lbs. CNS-B stated the direction to staff of 152 lbs was inaccurate as that reflected R3's weight when first admitted to the licensee in 2023. CNS-B further stated she would need to update the order. The licensee's 7.20 Medication & Treatment Orders policy dated August 26, 2021, indicated: 1) The RN (registered nurse) is responsible for assuring that: a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

DEPARTMENT OF HEALTH

Type: Full
Date: *02/24/25*
Time: 13:00:00
Report: 1033251085

Food and Beverage Establishment Inspection Report

Location:

Orchard Hill Senior Living
1223 Karl Drive
New Ulm, MN56073
Brown County, 08

Establishment Info:

ID #: 0038634
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073542159
ID #:

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

The following orders were issued during this inspection.

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

Wiping cloths stored soiled under counter equipment.
Comply By: 02/24/25

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Facility is using a household refrigerator.
Comply By: 02/24/25

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Quaternary Ammonium: = 400PPM at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Type: Full
Date: *02/24/25*
Time: 13:00:00
Report: 1033251085
Orchard Hill Senior Living

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 141 Degrees Fahrenheit - Location: Chicken-Hot Line
Violation Issued: No

Process/Item: Hot Holding
Temperature: 147 Degrees Fahrenheit - Location: Alfredo-Hot Line
Violation Issued: No

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Low Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Chest Freezer
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Household Fridge
Violation Issued: No

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

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

I acknowledge receipt of the inspection report number 1033251085 of 02/24/25.

Certified Food Protection Manager Kari E Apitz

Certification Number: FM105695 Expires: 03/10/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Kari E Apitz

Signed: _____
Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us

Report #: 1033251085

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

Date 02/24/25
Time In 13:00:00
Time Out

Orchard Hill Senior Living	Address: 1223 Karl Drive	City/State: New Ulm, MN	Zip Code: 56073	Telephone: 5073542159
License/Permit #: 0038634	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	X	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	X	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:** 02/25/25

Inspector (Signature)