Electronically Delivered

October 7, 2022

Administrator
Saint Therese Of Oxbow Lake
5200 Oak Grove Parkway
Brooklyn Park, MN 55443

RE: Project Number(s) SL30544015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 21, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division

Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

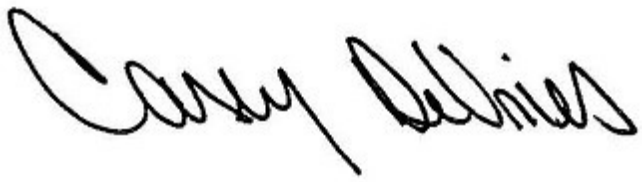
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

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

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30544	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE OF OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30544015-0 On September 19, 2022, through September 21, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 45 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care/Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3.	

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0 250	Continued From page 1	0 250		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250		

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September	0 250		

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0 250	Continued From page 3 19, 2022, at approximately 10:17 a.m., housing manager (HM)-C and licensed assisted living director (LALD)-D stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04	0 250		

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0 250	Continued From page 4 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250		

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0 250	Continued From page 5 - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by Authorized Agent (AA)-I on May 28, 2021. The licensee had an assisted living with dementia care license issued on August 1, 2022, with an expiration date of June 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - infection control practices; - reminders for treatments; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; and - supervision of unlicensed personnel performing delegated tasks.	0 250		

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0 250	Continued From page 6 On September 20, 2022, at 1:50 p.m., HM-C confirmed the licensee provided assisted living with dementia care but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0250, 0470, 0480, 0510, 0660, 0680, 0950, 0970, 1470, 1500, 1540, 1610, 1620, 1630, 1650, 1730, 1760, 1830, 1890, 1940, 2040, 2090, 2110, 2310, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (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	0 470		

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0 470	Continued From page 7 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 24-hour staffing schedule was posted in a central location for residents, staff and visitors to review as required. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 19, 2022, at 10:45 a.m., during a tour, the surveyor observed the licensee lacked the posting of a daily staffing schedule developed by the clinical nurse supervisor to: - direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked;	0 470		

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0 470	Continued From page 8 - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location. On September 19, 2022, at approximately 12:00 p.m., housing manager (HM)-C confirmed no staffing schedule was posted in a central location. HM-C stated all schedules are located online and only the staffing plan was posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced	0 480		

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0 480	Continued From page 9 by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated September 20, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of	0 510		

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0 510	Continued From page 10 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 complied with accepted health care, medical and nursing standards for infection control and for current recommendations related to COVID-19. This had the potential to affect all residents, staff and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On September 20, 2022, at approximately 9:30 a.m., the Center for Disease Control and Prevention (CDC) COVID Data Tracker for current community transmission indicated the licensee's county had a high transmission rate. The Minnesota Department of Health (MDH) personal protective equipment (PPE) grid for health care workers/direct service providers dated April 7, 2022, indicated when working with residents when community transmission rate is high, employees should wear a facemask and eye protection. On September 20, 2022, at approximately 6:45	0 510		

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SAINT THERESE OF OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 510	Continued From page 11 a.m., 8:00 a.m., and 10:20 a.m., the surveyor observed unlicensed personnel (ULP)-B, sitting with residents in the dining room without a facemask or eye protection. On September 20, 2022, at approximately 7:00 a.m., 9:10 a.m., and 11:10 a.m., the surveyor observed unlicensed personnel (ULP)-G, help feed a resident in the dining room without a facemask or eye protection. On September 20, 2022, at approximately 8:20 a.m., the surveyor observed ULP-G prepare medications for R1 without performing hand hygiene. On September 20, 2022, at approximately 12:45 p.m., registered nurse (RN)-A acknowledged the findings and stated all employees were asked to wear masks and eye protection around resident care areas and that there were no exceptions. RN-A also stated all staff will have infection control refresher courses to remind them of the expectations. The licensee's Infection Prevention and Control Program policy dated October 2022, indicated licensee has established and maintains an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of communicable diseases and infections as per accepted national standards and regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		

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0 660	Continued From page 12	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure tuberculosis (TB) education was provided to one of two employees (registered nurse (RN)-A). This had the potential to effect all 45 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 660		

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0 660	Continued From page 13 The Facility TB Risk Assessment dated June 2021 identified the facility was at a low risk for transmission. RN-A was hired and began providing assisted living services on February 3, 2020, as the clinical nurse supervisor. RN-A's personnel records lacked evidence RN-A completed TB training and education for health care workers. On September 20, 2022, at 12:45 p.m., housing manager (HM)-C acknowledged they provided the surveyor with a complete training list for RN-A and acknowledged the lack of TB training. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's Orientation policy dated August 1, 2021, indicated newly hired staff will receive orientation and training on topics required for assisted living organizations which included, "TB prevention and control." No further information was provided.	0 660		

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0 660	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two staff (registered nurse (RN)-A, unlicensed personnel (ULP)-B) received emergency preparedness	0 680		

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0 680	Continued From page 15 training and education upon hire and annually thereafter. This had the potential to effect all 45 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-A RN-A was hired and began providing assisted living services on August 15, 2022, as the clinical nurse supervisor. RN-A's personnel record contained a Relias (electronic training program) training log which lacked evidence of emergency preparedness training upon hire. ULP-B ULP-B was hired on February 3, 2020, and began providing assisted living services on August 1, 2021. ULP-B's personnel record contained a Relias training log which lacked evidence of emergency preparedness training upon hire and annually thereafter. On September 20, 2022, at 12:45 p.m., housing manager (HM)-C confirmed the Relias training logs contained both RN-A and ULP-B's completed training since their date of hire and lacked training topics related to emergency	0 680		

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0 680	Continued From page 16 preparedness. The licensee's Annual Training policy dated August 1, 2021, indicated all assisted living employees will complete annual education and training on, "Emergency and disaster training." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 950 SS=D	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a	0 950		

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0 950	Continued From page 17 designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the residents were given the opportunity to designate a representative when signing the assisted living contract as required for two of four residents (R2, R12). 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 R2 was admitted to licensee August 17, 2017, and started receiving assisted living services August 1, 2021. R2's diagnoses included dementia, chronic systolic heart failure and unspecified atrial fibrillation. R2's signed Residency Agreement dated January 6, 2022, included a section to identify or to decline a designated representative, but the section had not been completed. R12	0 950		

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0 950	Continued From page 18 R12 was admitted to licensee January 11, 2022. R12's diagnoses included unspecified dementia and essential hypertension. R12's signed Residency Agreement dated January 1, 2022, included a section to identify or to decline a designated representative, but the section had not been completed. On September 20, 2022, at approximately 11:30 a.m., housing manager (HM)-C acknowledged R2 and R12 had not designated representatives for certain purposes as required. HM-C stated it was an oversight on licensee's part when all other residents' contracts were updated and signed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the	0 970		

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0 970	Continued From page 19 facility's liability for health, safety or personal property of a resident for four of four residents (R2, R3, R4, R12). 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: R2 R2 was admitted to licensee August 17, 2017, under comprehensive license and began receiving assisted living services August 1, 2021. R2's Residency Agreement was signed January 6, 2022. R3 R3 admitted for services on June 18, 2010, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R3's Residency Agreement was signed on August 4, 2021. R4 R4 admitted and began receiving assisted living services on November 16, 2021. R4's Residency Agreement was signed on November 12, 2021. R12	0 970		

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0 970	Continued From page 20 R12 admitted and began receiving assisted living services on January 11, 2022. R12's Residency Agreement was signed January 1, 2022. R2, R3, R4 and R12's Residency Agreement, included a section titled Liability. The section indicated the owner was not liable to resident or resident's guest for any injury, death, or property damage occurring in the apartment or on the owner's premises unless such injury, death or property damage occurs as a result of an equipment malfunction or hazardous conditions within the building not caused by the resident or resident guest. In addition, the owner was not liable for injury, death or damage occurring as a result of the resident's receipt of health- related, supportive or other services from a third-party provider but may be liable to resident for its own negligent acts or those of its employees or agents. On September 20, 2022, at approximately 11:15 a.m., housing manager (HM)-C acknowledged resident contracts included a waiver of liability. HM-C stated licensee was in the process of signing updated contracts with the residents reflecting the requirement. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following	01470		

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01470	Continued From page 21 topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01470		

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01470	Continued From page 22 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to all required assisted living regulation content for two of two employees (registered nurse (RN-A), and unlicensed personnel (ULP)-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) 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: RN-A RN-A was hired and began providing assisted living services on August 15, 2022, as the clinical nurse supervisor.	01470		

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01470	Continued From page 23 RN-A's personnel record contained a Relias (electronic training program) training log, along with other training documents. RN-A's record lacked evidence of the following: - overview of assisted living statutes; - assisted living bill of rights; - handling emergencies and using emergency services; - handling resident/clients' complaints, reporting of complaints, where to report; and - assisted living services the employee will provide and principles of person-centered planning/services delivery. ULP-B ULP-B was hired on February 3, 2020, and began providing assisted living services on August 1, 2021. On September 20, 2022, at approximately 7:10 a.m., the surveyor observed ULP-B administer morning medications to R2 and later assist to put on Ted (thromboembolic-deterrent) hose stockings and corset belt. ULP-B's personnel record contained a Relias training log, along with other training documents. ULP-B's record lacked evidence of the following: - overview of assisted living statutes; - assisted living bill of rights; and - handling emergencies and using emergency services. On September 20, 2022, at approximately 9:25 a.m., housing manager (HM)-C confirmed ULP-B had not received training on current assisted living statutes and assisted living bill of rights effective August 1, 2021. HM-C also confirmed there was no documentation of emergency training for ULP-B.	01470		

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01470	Continued From page 24 On September 20, 2022, at 1:30 p.m., HM-C confirmed the licensee had not provided RN-A with the training and orientation to the items listed above. Licensee's Assisted Living Orientation for ULP Staff policy dated August 1, 2021, indicated, "Newly hired unlicensed personnel will receive orientation and training on topics required by Minnesota statutes and rules for assisted living." It further indicated training requirements in, "person-centered care." Licensee's Orientation - All Staff policy dated August 1, 2021, indicated employee training would include, "Orientation and training on topics required for assisted living organizations." It further indicated orientation must include the following topics: - An overview of Minnesota's assisted living law; - An introduction and review of agency policies and procedures related to the provision of assisted living services; - Emergency and disaster training; - Handling of emergencies and use of emergency services - Emergency and disaster preparedness plan - Procedures to use in handling various emergency - The assisted living bill of rights and staff responsibilities; - Principles of person-centered planning and service delivery and how they apply to direct support services; and - Complaint process. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01470		

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01470	Continued From page 25 (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01500		

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SAINT THERESE OF OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

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01500	Continued From page 26 (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-B). In addition, the licensee failed to include all required training topics for the annual training. 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).	01500		

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01500	Continued From page 27 The findings include: ULP-B was hired on February 3, 2020, and began providing assisted living services on August 1, 2021. On September 20, 2022, at approximately 7:10 a.m., the surveyor observed ULP-B administer morning medications to R2 and later assist to put on Ted (thromboembolic-deterrent) hose stockings and corset belt. ULP-B's record indicated required annual training of eight hours every 12 months lacked: - assisted living bill of rights; - infection control techniques; - eight hours of required annual training in required areas; only four hours were completed. On September 20, 2022, at 9:25 a.m., housing manager (HM)-C acknowledged ULP-B's record lacked hours and training topics to meet the 12-month annual training requirements. Licensee's Annual Training policy dated August 1, 2021, indicated all assisted living employees will complete annual training in the following topics: - reporting maltreatment and abuse; - assisted living bill of rights; - infection control techniques; - review of policies and procedures relating to the provision of assisted living services and how to implement them; - person-centered planning; and - staff will complete eight hours of annual training for each 12 months of employment. No further information was provided.	01500		

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01500	Continued From page 28 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame for two of two employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B). This had the potential to affect all residents 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	01540		

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01540	Continued From page 29	01540		

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:

RN-A
RN-A was hired and began providing assisted living services on August 15, 2022, as the clinical nurse supervisor.

On September 19, 2022, at approximately 10:20 a.m., during the entrance conference, RN-A stated her normal working hours were Monday through Friday, 8:00 a.m. to 4:30 p.m.

RN-A's personnel record contained a Relias (electronic training program) training log which indicated RN-A completed the following dementia care education:
- August 23, 2022, 0.25 hours;
- September 1, 2022, 3.5 hours;
- September 5, 2022, 0.35 hours.

RN-A's dementia training totaled 3.85 hours of the required eight hours to be completed within 120 working hours of employment start date under the assisted living statutes implemented August 1, 2021.

ULP-B
ULP-B was hired on February 3, 2020, and began proving assisted living services on August 1, 2021.

ULP-B's personnel record contained a Relias training log and email correspondence with house manager (HM)-C, which indicated ULP-B completed the following dementia care education:

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01540	Continued From page 30 - February 4, 2020, 4.0 hours; - August 12, 2021, 0.5 hours; - October 20, 2021, 0.5 hours; - September 28, 2021, 1.25 hours; - September 29, 2021, 1.75 hours; - March 17, 2022, 0.5 hours; - May 2, 2022, 0.25 hours; - September 2, 2022, 1 hour. ULP-B's dementia training totaled 5.75 hours of the required eight hours to be completed within 80 working hours of employment start date under the asssisted living laws implemented August 1, 2021. On September 20, 2022, at 1:30 p.m., house manager (HM)-C acknowledged RN-A and ULP-B lacked the required amount training hours for the hours worked. Licensee's Dementia Training policy dated December 3, 2021, indicated: - Supervisors of direct-care staff will: - complete a minimum of 8 hours initial training on dementia care topics - initial training will be completed within 120 working hours of the employment start date. - Direct-care staff will complete: - a minimum of 8 hours of initial training on dementia care topics - initial training will be completed within 160 [per State statute should read 80] working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		

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01610	Continued From page 31	01610		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to complete a pre-admission assessment by a registered nurse (RN) for one of one resident (R11) on or before the admission date. 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).	01610		

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01610	Continued From page 32 The findings include: R11 was admitted to licensee on September 19, 2022. On September 20, 2022, at approximately 7:30 a.m., the surveyor observed R11's medications in a Ziplock bag in the medication cart. On September 20, 2022, at approximately 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-B serve and deliver a room tray to R11. R11's Housing with Services Consultation form signed September 12, 2022, included a resident emergency contact information, telephone service agreement, satellite television service agreement and media release form. R11's unsigned Personal Profile form indicated R11 had a move in date of September 19, 2022. R11's record lacked a nursing assessment by a registered nurse of the physical and cognitive needs of the resident to propose a temporary service plan prior to the date on which R11 moved in. On September 20, 2022, at approximately 11:05 a.m., RN-A acknowledged R11's physical and cognitive needs assessment had not been completed. RN-A stated the licensee was not aware of the requirement. The Licensee's Nursing Assessment policy dated December 10, 2021, indicated nursing assessments are completed by a registered nurse based upon the required assessment schedule and as needed based upon resident	01610		

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01610	Continued From page 33 condition. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse	01620		

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01620	Continued From page 34 (RN) conducted ongoing resident monitoring and reassessments, not to exceed 90 calendar days from the last date of assessment for one of four residents (R3). In addition, the licensee failed to accurately reflect the licensee's ability to conduct change of condition assessments and update the service plan over the weekend for one of four 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: ONGOING ASSESSMENT R3 admitted for services on June 18, 2010, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R3's diagnosis included type 2 diabetes, stenosis of carotid arteries, convulsions, obesity, hypertension and alcohol dependence in remission. R3's Addendum Individualized Service Plan, dated September 3, 2021, indicated R3's services included meals, RN or licensed practical nurse (LPN) visits, diabetic foot care, home health aide (HHA) visits, laundry, medication set up and administration, anticoagulant management, blood glucose monitoring and assistance with insulin	01620		

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01620	Continued From page 35 administration. R3's record indicated the RN completed ongoing assessments on March 1, 2022, June 13, 2022, and September 14, 2022. Assessments dated June 13, 2022, and September 14, 2022, exceeded 90 calendar days from the last assessment. On September 20, 2022, at 9:13 a.m., RN-A verified R3's ongoing assessments exceeded 90 calendar days. RN-A stated the RN "typically" completed ongoing assessments by day 90. In addition, RN-A was unaware of why R3's assessments exceeded 90 days. The licensee's Nursing Assessment policy dated December 10, 2021, indicated the RN would determine the frequency of re-assessment based on the resident's needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. CHANGE OF CONDITION On September 19, 2022, at approximately 10:28 a.m., RN-A stated the RN's created a service plan based on a resident assessment. In addition, RN-A stated if there were a change in a resident's condition the RN would assess the resident and update the service plan. R3's Addendum Individualized Service Plan read "In the event that assisted living services are placed on hold due to a leave of absence, outing, nursing home admission, or hospitalization, all services will resume as previously contracted. Please note nurses are only on-site Monday through Friday 8 am - 4:30 pm. Thus, outside these hours new nursing services or changes to	01620		

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01620	Continued From page 36 this Service Plan Addendum cannot be made." On September 20, 2022, at 1:04 p.m., the surveyor inquired about the statement in the Addendum Individualized Service Plan listed above. Licensed assisted living director (LALD)-D acknowledged the statement could mislead a resident about the changes that could be made by the licensee on a weekend to the resident's care. LALD-D stated if a resident had a change of condition, and an assessment was needed, the licensee has an on-call RN and a RN on-site every other weekend that could complete an assessment and make updates to the service plan. The licensee's Nursing assessment policy dated December 10, 2021, indicated nursing assessments were completed as needed based upon resident's condition. In addition, if the resident had a change of condition the RN would review and update the service plan as necessary based on the resident's needs. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01630 SS=D	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced	01630		

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01630	Continued From page 37 by: Based on observation, interview and record review, the licensee failed to initiate a temporary service plan as required, for one of one resident (R11). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: R11 admitted to the licensee's memory care unit on September 19, 2022. On September 20, 2022, at approximately 7:30 a.m., the surveyor observed R11's medications in a Ziplock bag in the medication cart. On September 20, 2022, at approximately 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-B serve and deliver a room tray to R11. R11's Housing with Services Consultation form signed September 12, 2022, included a resident emergency contact information, telephone service agreement, satellite television service agreement and media release form. R11's unsigned Personal Profile indicated R11 had a move in date of September 19, 2022. R11's record lacked a temporary plan and agreement with the resident for services.	01630		

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01630	Continued From page 38 On September 20, 2022, at approximately 11:30 a.m., registered nurse (RN)-A acknowledged the licensee had not executed a temporary service plan with R11. RN-A stated R11's husband was responsible for R11's cares including her medications until an assessment was completed. RN-A stated in addition, the licensee was not aware of the temporary service plan requirement. Licensee's Contents of Service Plan policy dated December 10, 2021, indicated all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN. The policy lacked verbiage to include temporary service plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01630		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided;	01650		

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01650	Continued From page 39 (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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 to licensee February 10, 2021, under the comprehensive license and started receiving assisted living services August 1, 2021. R1's diagnosis included chronic kidney disease,	01650		

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01650	Continued From page 40	01650		

hyperlipidemia (high cholesterol), hypertension (HTN), chronic obstructive pulmonary disease (COPD) and osteoarthritis.

R1's Addendum Individualized Service Plan dated July 14, 2022, indicated R1 received the following services: shower, dining services, medication management, bathroom assistance, physical abilities, cognitive status, dressing, grooming, neb management and diabetes management.

R2
R2 was admitted to licensee August 17, 2017, under the comprehensive license and started receiving assisted living services August 1, 2021.

R2's diagnosis included congestive heart failure (CHF), major depression and HTN.

R2's Addendum Individualized Service Plan dated August 17, 2022, indicated R2 received the following services: shower, dining services, medication management, bathroom assistance, physical abilities, dressing, grooming, neb management and diabetes management.

R3
R3 admitted for services on June 18, 2010, under the comprehensive home care license and began receiving assisted living services on August 1, 2021.

R3's diagnosis included type 2 diabetes, stenosis of carotid arteries, convulsions, obesity, HTN and alcohol dependence in remission.

R3's Addendum Individualized Service Plan, dated September 3, 2021, indicated R3's services included meals, registered nurse (RN) or licensed practical nurse (LPN) visits, diabetic foot care,

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01650	Continued From page 41 home health aide (HHA) visits, laundry, medication set up and administration, anticoagulant management, blood glucose monitoring and assistance with insulin administration. R4 R4 admitted and began receiving assisted living services on November 16, 2021. R4's diagnoses included chronic respiratory failure, dependence of oxygen, severe protein-calorie malnutrition and HTN. R4's Addendum Individualized Service Plan, dated August 18, 2022, indicated R4 received escorts to meals, activities, medication management, laundry, assistance with dressing, assistance with grooming, assistance with compression stockings, and visits from RN, LPN and HHA as needed. R1, R2, R3, and R4's service plan lacked the following content: - methods of monitoring assessments; - methods of monitoring staff providing services; and - information and a method to contact the facility. On September 20, 2022, at 9:09 a.m., RN-A verified all resident service plans would lack a method of monitoring assessments, but all resident assessments were completed in person at the facility. The licensee's Contents of Service Plans policy dated December 10, 2021, indicated the service plan would include the missing content listed above.	01650		

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01650	Continued From page 42 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered	01730		

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01730	Continued From page 43 as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of four residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R4 admitted and began receiving assisted living services on November 16, 2021. R4's diagnoses included chronic respiratory failure, dependence of oxygen, severe protein-calorie malnutrition and hypertension. R4's Addendum Individualized Service Plan, dated August 18, 2022, indicated R4 received	01730		

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01730	Continued From page 44 escorts to meals, activities, medication management, laundry, assistance with dressing, assistance with grooming, assistance with compression stockings, and visits from registered nurse (RN), licensed practical nurse (LPN), and home health aides (HHA) as needed. R4's unsigned Order Summary Report dated September 19, 2022, included acetaminophen 500 milligrams (mg) to 1000 mg, albuterol sulfate 2.5 mg/0.5 milliliter (ml), Aspercreme lidocaine patch 4 percent (%), bacitracin ointment 500 units (U)/gram (gm), estradiol cream 2 gm, polyethylene glycol 17 gm, hydromorphone 1 mg, loperamide 2 mg to 4 mg, metoprolol succinate extended release (ER) 25 mg, ondansetron 4 mg, and senna 8.6 mg. R4's Medication Assessment Comprehensive dated June 27, 2022, indicated R4 received med (medication) set up only by facility nurse, medications were stored in original bottles in resident's room, controlled medications were stored in centralized store double locked, and indicated R4 was unable to safely administer medications. Information related to client [resident] specific instructions, and monitoring supplies/refills on the medication assessment was left blank. On September 20, 2022, at approximately 7:10 a.m., the surveyor observed unlicensed personnel (ULP)-E administer Aspercream lidocaine patch 4 % to the back of R4. On September 20, 2022, at approximately 7:24 a.m., the surveyor observed ULP-E remove a pre-set medication container from the facility medication cart and administer metoprolol succinate ER 25 mg to R4.	01730		

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01730	Continued From page 45 The individualized medication management plan lacked accurate information related to the following: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; and - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. On September 20, 2022, at approximately 12:28 p.m., RN-A stated if a resident received medication set up, medications would be stored in the resident's room. When the surveyor inquired why R4's medications were stored in the medication cart, and who was responsible for ordering R4's medications, RN-A stated they were unaware of the reason why, and the licensee ordered medication for R4. When asked why the licensee's practices related to R4's medication administration differed from R4's medication assessment, RN-A stated R4 frequently changed from self-administration of medication to having the licensee provide medication administration. The licensee's Medication, Treatment and Therapy Reminders policy dated December 10, 2021, indicated prior to providing any medication a RN would conduct a nursing assessment of a resident's functional status and need for medication management services and develop an individualized medication management plan. No further information provided.	01730		

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01730	Continued From page 46 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered per providers orders for one of seven residents (R6). 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).	01760		

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01760	Continued From page 47 The findings include: R6 admitted and began receiving assisted living services on April 15, 2021. R6's diagnoses included hypertension, dry eye, hypothyroidism, type 2 diabetes, major depression, anxiety disorder, obstructive sleep apnea, diverticulosis of large intestine and amnesia. R6's Addendum Individualized Service Plan, signed June 9, 2022, indicated R6 received services for bathing, dressing, grooming, laundry, medication management, ted stockings and escorts. R6's electronic medication administration record (EMAR) dated September 1, 2022, to September 30, 2022, indicated the following medications were to be administered at 8:00 a.m.- Benefiber 1 tablespoon (tbsp), levothyroxine 112 micrograms (mcg), acetaminophen extended release (ER) 650 milligrams (mg) and Refresh Optive solution 0.5-0.9 percent (%). R6's unsigned Order Summary Report dated September 20, 2022, included Benefiber one tbsp by mouth one time per day. On September 20, 2022, at approximately 7:50 a.m., unlicensed personnel (ULP)-E stated R6 experienced diarrhea when staff provided Benefiber per provider order. Instead, ULP-E stated staff provided a half dose of Benefiber to R6 to avoid R6 from experiencing diarrhea. The surveyor then observed ULP-E pour 1 ½ teaspoons (tsp) of Benefiber into medication cup. On September 20, 2022, at approximately 7:54	01760		

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01760	Continued From page 48 a.m., the surveyor observed ULP-E administer 1 ½ tsp of Benefiber to R6 and document 1 tbsp of Benifiber was administered to R6. On September 20, 2022, at approximately 8:03 a.m., ULP-E stated they previously notified the nurse about the dosage of Benefiber being administered to R6. On September 20, 2022, at approximately 9:05 a.m., registered nurse (RN)-A stated medication orders would be administered as prescribed. In addition, RN-A stated if a medication change was needed due to side effects, the nurse would contact the provider to change the medication order. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated December 10, 2021, indicated medications would be administered according to the "6 Rights" which included right dose. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01830		

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01830	Continued From page 49	01830		

licensee failed to ensure prescriptions were renewed at least every 12 months for one of four residents (R4).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 admitted for services on June 18, 2010, under the comprehensive home care license and began receiving assisted living services on August 1, 2021.

R3's diagnosis included type 2 diabetes, stenosis of carotid arteries, convulsions, obesity, hypertension and alcohol dependence in remission.

R3's Addendum Individualized Service Plan, dated September 3, 2021, indicated R3's services included meals, registered nurse (RN) or licensed practical nurse (LPN) visits, diabetic foot care, home health aide (HHA) visits, laundry, medication set up and administration, anticoagulant management, blood glucose monitoring and assistance with insulin administration.

R3's unsigned Order Summary Report dated September 19, 2022, included acetaminophen 325 milligrams (mg) or 650 mg, atorvastatin calcium 40 mg, coumadin 2.5 mg or 5 mg, Lantus

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01830	Continued From page 50 SoloStar 23 units (U), Lantus SoloStar 30 U, and polyethylene glycol 17 grams (gm). R3's signed provider orders dated August 7, 2021, included atorvastatin calcium 40 mg, and acetaminophen 325 mg to 650 mg. R3's record lacked a prescription renewal every 12 months for atorvastatin calcium and acetaminophen. On September 20, 2022, at 9:02 a.m., RN-A verified R3's medical record lacked a prescription renewal every 12 months for the two medications listed above. RN-A stated the licensee renews prescriptions yearly and was unaware of why the prescriptions was not renewed timely. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for two of 20 residents (R1, R2) and failed to discard expired medication for five of 20 residents (R1, R2, R7,	01890		

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01890	Continued From page 51 R8, R10). In addition, the licensee failed to ensure time sensitive medications were labeled with the date opened for three of three residents (R3, R7, 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, 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 the potential to affect a large portion or all of the residents). The findings include: PRESCRIPTION LABEL On September 20, 2022, at approximately 10:00 a.m., the surveyor observed the memory care unit medication cart and observed the following unlabeled medications: - R1 phenylephrine hydrochloride 10 milligram (mg); - R1 debrox carbamide peroxide (earwax removal); - R1 clearlax polyethylene glycol 3350; - R1 women's complete multivitamin; - R2 alfalfa 650 mg; - R2 calcium 600 mg; - R2 ocuvite eye vitamin and mineral supplement; - R2 acetaminophen gelcaps 500 mg; and - R2 B-complex. The licensee's Storage of Medication policy dated August 1, 2021, indicated a medication would be kept in its original container bearing the original prescription label with legible information.	01890		

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01890	Continued From page 52 EXPIRED MEDICATIONS On September 20, 2022, at 7:35 a.m., the surveyor observed the third-floor medication cart and observed the following expired medications: - R7 multivitamins with an expiration date of September 2019; and - R8 Theratears 0.25 percent (%) two bottles with an expiration date of August 2022. On September 20, 2022, at approximately 7:45 a.m., unlicensed personnel (ULP)-E verified R7 and R8's medications were expired. ULP-E stated when medication is administered staff check the expiration date and if a medication was expired, staff would tell a nurse to remove the expired medication from the cart. On September 20, 2022, at approximately 9:04 a.m., registered nurse (RN)-A stated expired medication would be removed from medication carts and destroyed by the nurses at the facility unless it was a medication provided by family. On September 20, 2022, at approximately 10:00 a.m., the surveyor observed the memory care unit medication cart, and observed the following expired medications: - R1 fluticasone propionate expired June 30, 2022; - R2 mouth moistener expired November 25, 2021; - R9 clear eyes redness relief expired March 15, 2022; - R10 acetaminophen 500 mg tablets expired August 2022; - R10 zinc oxide 20 % ointment expired January 21, 2021; - R10 calmoseptine menthol expired December 17, 2021; and	01890		

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01890	Continued From page 53 - R10 brimonidine tartrate ophthalmic solution expired July 2022. On September 20, 2022, at approximately 10:00 a.m., ULP-G confirmed the medications were expired and stated the nurses were responsible to check for expired medications. On September 20, 2022, at approximately 11:20 a.m., RN-A acknowledged the findings and stated nurses audit the carts every month to remove expired medications. TIME SENSITIVE MEDICATIONS On September 20, 2022, at 7:35 a.m., the surveyor observed the third-floor medication cart and observed the following time sensitive medications were opened without a date opened label: - R7 timolol maleate 0.5 %; - R13 latanoprost 0.005 %; and - R15 dorzolamide hydrocloride-timolol 22.3 mg-6.8 milliliter (ml). On September 20, 2022, at approximately 7:45 a.m., ULP-E verified R7, R8, R15 eyedrops were not labeled with date open. ULP-E stated they used the expiration on the prescription label to tell when to discard. ULP-E stated they did not know medications were time sensitive. ULP-E stated the nurse would place a date opened sticker on medication bottle if needed however, eye drops were used normally within a month. On September 20, 2022, at approximately 8:05 a.m., the surveyor observed R3's medication cabinet in R3's room and noted a Lantus Solostar pen was not labeled with date opened. On September 20, 2022, at approximately 9:04	01890		

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01890	Continued From page 54 a.m. RN-A stated time sensitive medication should have a date opened label. When the surveyor inquired why all the eye drops on the third-floor medication cart did not have a label with date opened, RN-A stated the nurses were supposed to label bottles with date opened however, was unsure why the bottles did not have label present. The manufacturer's instructions for the use of timolol maleate 0.5 % dated February 2009, directed the eye drop to be discarded one month after date of opened. The manufacturer's instructions for the use of lantanoprost 0.005 % dated August 2011, directed the eye drop to be discarded 6 weeks after date opened. The manufacturer's instructions for the use of dorzolamide hydrochloride-timolol dated June 2017, directed the eye drop be discarded after 15 days after date opened. The manufacturer's instruction for the use of Lantus Solostar pen dated March 2020, directed insulin to be discarded 28 days after date opened. The licensee's Storage of Medication policy dated August 1, 2021, indicated a medication container would bear the expiration date of a time-dated drug. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01940	Continued From page 55	01940		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to include in the service plan the treatments the resident received for two of four residents (R2, R4). In addition,	01940		

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01940	Continued From page 56 licensee failed to develop and implement a treatment or therapy management plan to include all required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 to licensee February 10, 2021, under the comprehensive license and began receiving assisted living services August 1, 2021. R1's Addendum Individualized Service Plan dated July 14, 2022, indicated R1 received the following services: shower, dining services, medication management, bathroom assistance, physical abilities, cognitive status, dressing, grooming, neb management and diabetes management. R1's Weights and Vitals Summary log dated between February 10, 2021, and September 19, 2022, indicated R1's blood pressures ranged between 99/41 and 174/55mmHg (millimeters of mercury, a unit of pressure). R1's treatment and/or therapy management plan failed to include information for when unlicensed personnel (ULP)should notify an RN or appropriate licensed health professional or when a problem arises.	01940		

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01940	Continued From page 57 R2 R2 was admitted to licensee August 17, 2017, under the comprehensive license and began receiving assisted living services August 1, 2021. On September 20, 2022, at approximately 7:10 a.m., the surveyor observed ULP-B administer morning medications to R2 and later assist to put on Ted hose (thromboembolic-deterrent) stockings and corset belt. R2's Addendum Individualized Service Plan dated August 17, 2022, indicated R2 received the following services: shower, dining services, medication management, bathroom assistance, physical abilities, dressing, grooming, neb management and diabetes management. R2's Individualized Service Plan lacked treatments R2 received to include TEDS application every morning and off at bedtime, and application of lumbar corset around waist every morning and off at bedtime. On September 20, 2022, at approximately 11:45 a.m., registered nurse (RN)-A acknowledged R2's service plan was missing scheduled treatments that R2 received. RN-A also stated they were not sure how that happened but would update R2's service plan to reflect the current services received. R3 R3 admitted for services on June 18, 2010, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R3's Addendum Individualized Service Plan, dated September 3, 2021, indicated R3's services included meals, RN or licensed practical nurse	01940		

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01940	Continued From page 58 (LPN) visits, diabetic foot care, home health aide (HHA) visits, laundry, medication set up and administration, anticoagulant management, blood glucose monitoring and assistance with insulin administration. R3's signed provider orders dated August 20, 2021, included blood glucose testing twice per day. On September 20, 2022, at approximately 8:05 a.m., the surveyor observed ULP-F assist R3 with blood glucose monitoring. ULP-F set up the blood glucose machine, handed blood glucose monitoring supplies to R3, and documented the blood glucose level of R3 in Point Click Care (a documenting software system). The surveyor inquired to ULP-F about when staff would contact a nurse regarding R3's blood glucose. ULP-F stated if a blood glucose was above 250. The surveyor inquired where in the record it alerted staff to contact the nurse. ULP-F stated there was nothing to tell them to contact a nurse, they just knew from previous experience. On September 20, 2022, at 8:47 a.m., RN-A stated, "I see we do not have parameters for staff to notify us." In addition, RN-A stated they would contact provider to obtain parameters for blood glucose. R4 R4 admitted and began receiving assisted living services on November 16, 2021. R4's Addendum Individualized Service Plan, dated August 18, 2022, indicated R4 received escorts to meals, activities, medication management, laundry, assistance with dressing, assistance with grooming, assistance with	01940		

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01940	Continued From page 59 compression stockings, and visits from RN, LPN, and HHA as needed. R4's Individualized Service Plan lacked oxygen management. R4's Order Summary Report dated September 19, 2022, included continuous oxygen 3liters (L) to 3.5 L. On September 20, 2022, at 7:10 a.m., the surveyor observed ULP-E apply R4's compression stockings to bilateral (two sides) legs, assist with placement of oxygen canula, and obtain an oxygen saturation level reading from R4. R1, R2, R3 and R4's individual treatment and/or therapy management plan lacked procedures for notifying an RN or appropriate licensed health professional when a problem arises with treatments or therapy services. On September 20, 2022, at approximately 8:49 a.m., RN-A verified R3 and R4's treatment plan lacked when to notify a nurse if a problem arises with a treatment. RN-A stated they were unaware resident's treatment plans needed to have a statement of when to notify the nurse. The licensee's Medication, Treatment and Therapy Reminders policy dated December 10, 2021, indicated prior to providing any treatment and therapy reminders, the RN will conduct a nursing assessment of a resident's functional status and need for treatment and therapy reminders or treatment and therapy management service and develop a treatment and therapy individualized plan for the resident based on the resident's needs and preferences. No further information provided.	01940		

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01940	Continued From page 60 TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. 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 the potential to affect a large portion or all residents). The findings include:	02040		

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02040	Continued From page 61 A review of the Hazard Vulnerability Assessment showed global issues such as fire, gas leaks, and epidemics had been identified. Local hazards that are site, building, and population-specific had not been developed. During an interview on September 21, 2022, at 11:45 a.m., Housing Manager (HM)-C stated that the hazard vulnerability assessment on and around the facility property was incomplete. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02090 SS=F	144G.82 Subdivision 1 General The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain a dignified dining experience for all of the memory care residents during the breakfast meal period. 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	02090		

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02090	Continued From page 62 or has the potential to affect a large portion or all of the residents). The findings include: On September 20, 2022, at approximately 7:50 a.m., the surveyor observed staff serve residents breakfast in the memory care unit dining room. On September 20, 2022, at approximately 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-H enter the dining room and walk through the serving area, while the residents were eating, carrying a transparent trash bag that contained soiled incontinence briefs. ULP-H entered another room behind the serving area. On September 20, 2022, at approximately 8:20 a.m., the surveyor observed ULP-G enter the dining room through the rear door and into the serving area carrying a transparent trash bag that contained soiled incontinence briefs. ULP-G walked into another room behind the serving area. On September 20, 2022, at approximately 9:10 a.m., ULP-H stated the room the ULPs entered from the serving area led to the trash area. ULP-H stated there was no other way to access the trash area. On September 20, 2022, at approximately 11:20 a.m., registered nurse (RN)-A acknowledged the surveyor's observations and stated the licensee would retrain staff to wait until breakfast and generally all mealtimes are over before carrying out trash from resident rooms. No further information was provided.	02090		

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02090	Continued From page 63 TIME PERIOD FOR CORRECTION: Seven (7) days	02090		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and	02110		

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02110	Continued From page 64 designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents and the residents' legal and designated representatives at the time of move in for two of four 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 of the residents). The findings include: R1 was admitted to licensee February 10, 2021, under the comprehensive home care license and began receiving assisted living services August 1, 2021. R3 admitted for to the licensee on June 18, 2010, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1 and R3's records lacked evidence the licensee provided the resident, or resident's designated representative, the updated dementia training disclosure to include policies and procedures as of August 1, 2022, for the Assisted Living Facility with Dementia Care (ALFDC) license.	02110		

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02110	Continued From page 65 On September 20, 2022, 12:45 p.m., housing manager (HM)-C stated she did not have the 10 dementia policies required for an ALFDC. On September 20, 2022, at 1:14 p.m., licensed assisted living director (LALD)-C stated none of the licensee's residents, who were admitted before or after August 1, 2022, were provided with the 10 dementia policies required for an ALFDC. The licensee's Dementia Training Disclosure, undated, indicated required dementia training but lacked required dementia policies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02310 SS=F	144G.91 Subd. 4 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 provide care and services according to acceptable health care standards, medical or nursing standards with medication administration for four of four residents (R1, R12, R13, R14). This practice resulted in a level two violation (a	02310		

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02310	Continued From page 66	02310		

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 to licensee February 10, 2021, under the comprehensive license and began receiving assisted living services August 1, 2021.

R1's Addendum Individualized Service Plan dated July 14, 2022, indicated R1 received the following services: medication management, bathroom assistance, physical abilities, cognitive status, dressing, grooming, neb management and diabetes management.

R12
R12 was admitted to licensee January 11, 2022.

R12's Addendum Individualized Service Plan dated July 14, 2022, indicated R12 received the following services: medication management, bathroom assistance, physical abilities, cognitive status, dressing, grooming and neb management.

R13
R13 was admitted to licensee February 25, 2020, under the comprehensive license and began receiving assisted living services August 1, 2021.

R13's Addendum Individualized Service Plan dated July 14, 2022, indicated R31 received the following services: medication management, bathroom assistance, physical abilities, cognitive

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SAINT THERESE OF OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

(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
02310	Continued From page 67 status, dressing, grooming, neb management, and diabetes management. R14 R14 was admitted to licensee July 20, 2022. R14's Addendum Individualized Service Plan dated July 20, 2022, indicated R14 received the following services: medication management, bathroom assistance, physical abilities, cognitive status, dressing, grooming, neb management and diabetes management. On September 20, 2022, at approximately 7:20 a.m., the surveyor observed unlicensed personnel (ULP)-G without use of a medication administration record, pre-set medication from pharmacy bubble packs into unlabeled medication cups for R1, R12, R13, and R14. On September 20, 2022, at approximately between 7:30 a.m., and 7:40 a.m., the surveyor observed ULP-G administer medications to R1, R12, R13, and R14 in the dining room. On September 20, 2022, at approximately 9:40 a.m., ULP-G stated she was trained by the registered nurse (RN) on medication administration and followed another ULP on the floor for a week before starting to pass medications independently. On September 20, 2022, at approximately 11:45 a.m., RN-A acknowledged the findings and stated all ULPs go through a medication administration training program and are provided a step-by-step procedure on how to identify the six medication administration rights for every resident before giving medication. RN also stated ULPs cannot set up medications as this is RN responsibility	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30544	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT THERESE OF OXBOW LAKE	5200 OAK GROVE PARKWAY BROOKLYN PARK, MN 55443

(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
02310	Continued From page 68 only. Licensee's training Unlicensed Personnel for Medication, Treatment and Therapy Administration policy dated December 10, 2021, indicated before RN delegates the task of assistance with self-administration of medications or the tasks of medication administration the RN will instruct the unlicensed personnel on performing these tasks and determine competence to perform the task. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Type: Full
Date: *09/20/22*
Time: 10:30:50
Report: 1024221159

Food and Beverage Establishment Inspection Report

Location:
Saint Therese Of Oxbow Lake
5200 Oak Grove Parkway
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0038716
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7634937000
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.

3-500A Microbial Control: cooling

3-501.14A ** Priority 1 **

MN Rule 4626.0385A Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.

ALL METAL PANS OF CLAM CHOWDER MADE YESTERDAY, 9/19, MEASURED BETWEEN 44-50 dF AND WERE ALL DISCARDED ON SITE. DISCUSSED METHODS OF COOLING. COMPLY PER ABOVE RULE.

Comply By: 09/20/22

4-500 Equipment Maintenance and Operation

4-501.114C3 ** Priority 1 **

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

QUATERNARY AMMONIUM DISPENSER MEASURED 50 PPM. UPON OBSERVATION, DISPENSER SOLUTION CONTAINER WAS EMPTY. CONTAINER WAS REPLACED AND DISPENSER MEASURED 400 PPM.

Corrected on Site

3-300B Protection from Contamination: cross-contamination, eggs

3-302.15B ** Priority 2 **

MN Rule 4626.0255B Follow the manufacturer's instructions for devices used for on-site generation of chemicals for washing raw, whole fruits and vegetables.

VEGETABLE WASH MEASURED 0 PPM. UPON OBSERVATION, NO SOLUTION WAS IN TUBE LINING AND PERSON IN CHARGE HAD TO TIGHTEN CAP IN ORDER FOR SOLUTION TO BE SUCKED UP INTO TUBES. ADVISED TO ENSURE SOLUTION IS ALWAYS VISIBLE IN TUBES AND TO TEST PRIOR TO EACH USE.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO IRREVERSIBLE THERMOMETER OR TEMPERATURE TEST STRIPS ON SITE. ADVISED TO PROVIDE AND MAINTAIN IN ORDER TO MEASURE UTENSIL SURFACE TEMPERATURE OF DISHWASHING MACHINE ENSURING IT REACHES 160 dF OR HIGHER.

Comply By: 09/20/22

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

OBSERVED SMALL CRAMMED SPACE TO ACCESS HANDWASHING SINK AT BISTRO AREA DUE TO ICE CREAM FREEZER PLACEMENT. EQUIPMENT WAS MOVED TO ALLOW FOR MORE SPACE TO HANDWASHING SINK AT TIME OF INSPECTION.

Corrected on Site

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

3-304.14D

MN Rule 4626.0285D Provide an approved sanitizing solution for storage of the wet wiping cloths that is free of food debris and visible soil.

OBSERVED TOWEL IN SOAPY WATER BUCKET MEASURING 0 PPM. WET TOWEL WAS REMOVED FROM SOAPY WATER BUCKET. ADVISED TO USE A NEW TOWEL EACH TIME WHEN USING IT WITH SOAPY WATER BUCKET. ADVISED TO MAINTAIN ALL WET TOWELS IN APPROVED SANITIZING SOLUTION.

Corrected on Site

Surface and Equipment Sanitizers

Quaternary Ammonium: = 50 PPM at Degrees Fahrenheit
Location: Q.A. SANI DISPENSER
Violation Issued: Yes

Quaternary Ammonium: = 400 PPM at Degrees Fahrenheit
Location: SANI BUCKET - MAIN LINE
Violation Issued: No

Quaternary Ammonium: = 0 PPM at Degrees Fahrenheit
Location: SOAPY WATER BUCKET W/TOWEL
Violation Issued: Yes

Produce Wash: = 0 PPM at Degrees Fahrenheit
Location: PRODUCE WASH DISPENSER
Violation Issued: Yes

Produce Wash: = 1391 PPM at Degrees Fahrenheit
Location: PRODUCE WASH DISPENSER
Violation Issued: No

Quaternary Ammonium: = 400 PPM at Degrees Fahrenheit
Location: Q.A. SANI DISPENSER - REPLACED
Violation Issued: No

Utensil Surface Temp: = at 161 Degrees Fahrenheit
Location: DISHWASHING MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/CHEESE
Temperature: 36 Degrees Fahrenheit - Location: BASEMENT WALK IN COOLER
Violation Issued: No

Process/Item: Receiving Temp/DELI MEAT
Temperature: 41 Degrees Fahrenheit - Location: DELIVERY TRUCK TO BASEMENT WALK IN COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 39 Degrees Fahrenheit - Location: DESSERT 2-DOOR COOLER
Violation Issued: No

Process/Item: Cold Holding/SLICED TOMATO
Temperature: 40 Degrees Fahrenheit - Location: NORLAKE ADVANTEDGE PREP TOP COOLER
Violation Issued: No

Process/Item: Cold Holding/CHICKEN
Temperature: 39 Degrees Fahrenheit - Location: NORLAKE ADVANTEDGE LOWER COOLER
Violation Issued: No

Process/Item: Hot Holding/ITALIAN SOUP
Temperature: 182 Degrees Fahrenheit - Location: STEAM TABLE - MAIN LINE
Violation Issued: No

Process/Item: Cook Temp/BEEF
Temperature: 183 Degrees Fahrenheit - Location: MAIN LINE
Violation Issued: No

Process/Item: Cooling/CLAM CHOWDER
Temperature: 44 Degrees Fahrenheit - Location: MAIN WALK IN COOLER
Violation Issued: Yes

Process/Item: Cooling/CLAM CHOWDER
Temperature: 50 Degrees Fahrenheit - Location: MAIN WALK IN COOLER
Violation Issued: Yes

Process/Item: Cooling/CLAM CHOWDER
Temperature: 47 Degrees Fahrenheit - Location: MAIN WALK IN COOLER
Violation Issued: Yes

Process/Item: Cold Holding/PASTA
Temperature: 38 Degrees Fahrenheit - Location: MAIN WALK IN COOLER
Violation Issued: No

Process/Item: Cold Holding/CUT TOMATOES
Temperature: 39 Degrees Fahrenheit - Location: ARCTIC AIR PREP TOP COOLER - BISTRO
Violation Issued: No

Process/Item: Cold Holding/HAM
Temperature: 39 Degrees Fahrenheit - Location: ARCTIC AIR LOWER PREP COOLER - BISTRO
Violation Issued: No

Process/Item: Cold Holding/MILK
Temperature: 37 Degrees Fahrenheit - Location: 2-DOOR DISPLAY COOELR - BISTRO
Violation Issued: No

Process/Item: Hot Holding/TACO MEAT
Temperature: 164 Degrees Fahrenheit - Location: NEMCO WARMER
Violation Issued: No

Process/Item: Hot Holding/ITALIAN SOUP
Temperature: 138 Degrees Fahrenheit - Location: APW WYOTT WARMER
Violation Issued: No

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

DISCUSSED THE FOLLOWING WITH TERESA WITTMANN WITH ST. THERESE AT OXBOW LAKE IN ADDITION TO NURSING EVALUATORS ASHLEY CREWS AND JOEY KEEN:

- ALL ORDERS ON REPORT.
- BISTRO AND MAIN KITCHEN AREAS WERE INSPECTED.
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- REPORTABLE DISEASES.
- HANDWASHING POLICY AND REVIEW.
- VOMIT AND FECAL MATTER CLEAN UP PROCEDURES.
- CFPM.
- THERMOMETER USE.
- THERMOMETER CALIBRATION AND FREQUENCY.
- DATE MARKING AND DISCARD DATE.
- PROPER TEMPERATURES AND METHODS FOR COOLING.

- PROPER SANITIZING LEVELS FOR QUATERNARY AMMONIUM AND VEGETABLE WASH.
- PEST CONTROL.

- GOOD LIFE CAFE HAS BEEN AND WAS CLOSED DUE TO SHORT STAFF AND COVID-19 AND WAS NOT INSPECTED AT TIME OF INSPECTION.

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 1024221159 of 09/20/22.

Certified Food Protection Manager: TERESA A. WITTMANN

Certification Number: FM91759 Expires: 12/07/23

Signed: _____

TERESA WITTMANN
PERSON IN CHARGE

Signed: _____

Sheng Yang
Public Health Sanitarian I
Freeman Building
651-201-3985
sheng.yang@state.mn.us