DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 17, 2025

Licensee
Comfort Care Cottages
1232 Jefferson Street South
Wadena, MN 56482

RE: Project Number(s) SL30454015

Dear Licensee:

On May 6, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on July 2, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Benjamin Zwart

Benjamin J. Zwart, Supervisor
State Engineering Services Section
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

CLN

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

November 4, 2024

Licensee
Comfort Care Cottages
1232 Jefferson Street South
Wadena, MN 56482

RE: Conditional License Number 414963
Health Facility Identification Number (HFID) 30454
Project Number(s) SL30454015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on September 30, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **February 2, 2025**.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 2, 2024, found not corrected at the time of the September 30, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0680 - Disaster Planning And Emergency Preparedness - 144g.42 Subd. 10 - $500.00
0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1) - $500.00
0790 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (2)-(3) - $500.00
0810 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (b)-(f) - $500.00
0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on September 30, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

Also, at the time of this follow-up survey completed on September 30, 2024, we identified the following violation(s):

0510 - Infection Control Program - 144g.41 Subd. 3

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

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

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

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

The correction order documentation should include the following:

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

the specific statute(s).

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

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

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

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

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

CONDITIONAL LICENSE ISSUED:
MDH will issue Comfort Care Cottages a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Comfort Care Cottages is in substantial compliance.

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

a. **Health Facility Construction Permit:** Comfort Care Cottages, will contact The Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. Within 21-days from the date of this notice, Comfort Care Cottages, will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.

b. **General Contractor:** Comfort Care Cottages must provide the following to Benjamin J. Zwart (Benjamin.Zwart@state.mn.us) via email within 21-days of the date of this notice:
    i. Name
    ii. License Number
    iii. Contact Information

c. **Egress Window Requirements:** Comfort Care Cottages will replace at least one window in occupied resident sleeping room, unit #20 of house #3, and unoccupied resident sleeping room, unit #21 of house #3, meeting the minimum size requirements.

    i. Must have a minimum openable width of no less than 20 inches
    ii. Must have a minimum openable height of no less than 20 inches
    iii. Must have a total openable area of no less than 648 square inches (4.5 square feet)
    iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening
    v. All measurements must be achieved under normal operation of opening window without the use of a key, tool or special knowledge

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Comfort Care Cottages is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Comfort Care Cottages is in substantial compliance on the follow up survey, MDH will remove the conditions from Comfort Care Cottages's assisted living facility license, and Comfort Care Cottages will correct any outstanding violations identified during the survey. If Comfort Care Cottages is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRD-Appeals-Form**.

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

If you have any questions, please contact Jessie Chenze directly at: 218-332-5175.

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30454	A. BUILDING: _____ B. WING _____	R 09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE COTTAGES	1232 JEFFERSON STREET SOUTH WADENA, MN 56482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30454015-1 On September 30, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on July 2, 2024. At the time of the survey, there were 11 residents; 11 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were issued and reissued.	{0 000}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		

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0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for environmental cleaning. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On follow-up survey on September 30, 2024, at 11:15 a.m., the surveyor and licensed assisted living director (LALD)-A observed House #1 to	0 510		

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0 510	Continued From page 2 ensure compliance of a two-hour fire separation wall between private and assisted living spaces was completed. LALD-A stated no two-hour firewall was placed as non-residents whom were living in the private space moved out. Upon entering the kitchen portion, surveyor observed a bowl of fresh fruit on the table, a fresh onion and a coffee pot with warm coffee on the counter, and an odor. LALD-A stated staff will make coffee for the resident living in the assisted living side of the house, and staff may use the kitchen for a break room, he is not sure why there was a fresh onion, as the resident does not cook. The upstairs consisted of a small hallway, two bedrooms and a full bathroom. The surveyor observed dried cat feces on the hallway and bathroom floor, and clothing and clutter strewn in one of the bedrooms. LALD-A stated the cat feces needs to be cleaned up and the area needs to be cleaned. LALD-A stated the resident currently residing in House #1 doesn't go up the stairs as he is in a wheelchair. LALD-A stated there is a cat in the house, which the resident likes and feeds. The surveyor observed the litterbox and cat food items in a room off the kitchen. On September 30, 2024, at 2:45 p.m., licensed assisted living director (LALD)-A stated and agreed the cat feces was an infection control issue, as the feces can be tracked by shoes into other assisted living spaces making it an environmental hazard. The Center of Disease Control (CDC) Infection Control -Animals in Healthcare Settings dated January 8, 2024, indicated the most important infection control measure to prevent potential disease transmission is strict enforcement of hand hygiene measures (e.g., using either soap and water or an alcohol-based hand rub) for all	0 510		

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0 510	Continued From page 3 patients, staff and residents handling animals. Care should be taken to avoid direct contact with animal urine and feces. Clean up of these substances from environmental surface require gloves and use of leak-resistant plastic bags to discard absorbent material int the process. The area must be cleaned after visits according to the standard cleaning procedures. The licensee's Infection Control - 8.05 Disinfection Environmental Surfaces policy dated January 3, 2024, indicated good infection control practice mandates that environmental surfaces be kept clean and free from contamination. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and	{0 680}		

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{0 680}	Continued From page 4 disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post the emergency preparedness plan prominently. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On follow-up survey on September 30, 2024, at 10:37 a.m., the surveyor requested to see the Emergency Preparedness Plan Manual for the facility from the unlicensed personnel (ULP)-F. ULP-F stated the books are locked in the cabinet in the kitchen. ULP-F unlocked the cabinet and stated the EPP is not there, I am not sure where it (EPP) is, but would call 911 if there was a fire. On September 30, 2024, at 1:00 p.m., the EPP manual was found upstairs in the nursing office	{0 680}		

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{0 680}	Continued From page 5 on a desk. The licensed assisted living director (LALD)-A stated the EPP was not posted prominently, nor was there a posting where the EPP could be found. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided.	{0 680}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or	{0 780}		

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{0 780}	Continued From page 6 sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected throughout the facility so that actuation of one alarm will cause all alarms in the dwelling to actuate. The licensee also failed to provide a smoke alarm in residents sleeping rooms. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a follow up survey on September 30, 2024, at 11:30 a.m., with owner/licensed assisted living director (O/LALD)-A, survey staff observed that smoke alarms throughout the facility were not interconnected so that actuation of one alarm will cause all alarms in the dwelling to actuate. This was discovered when the O/LALD-A tested the	{0 780}		

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{0 780}	Continued From page 7 smoke alarms in each of the four houses and they could not be heard throughout the facilities. Smoke alarms were missing in bedroom #10 and in the two bedrooms upstairs. Smoke alarms should be provided in each sleeping room. O/LALD stated he would get these smoke alarms replaced as soon as possible.	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide documentation of yearly and monthly inspections of all the fire extinguishers. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	{0 790}		

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{0 790}	Continued From page 8 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a follow up survey, on September 30, 2024, at 10:30 a.m., survey staff conducted a facility tour with owner/licensed assisted living director (O/LALD)-A, survey staff observed that the fire extinguishers in all four houses did not have documentation of yearly and monthly inspections. Yearly and monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order.	{0 790}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year	{0 810}		

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{0 810}	Continued From page 9 thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a follow up survey, on September 30, 2024, at	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30454	A. BUILDING: _____ B. WING _____	R 09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{0 810}	Continued From page 10 11:05 a.m. record review and interview were conducted with owner/licensed assisted living director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the FSEP (fire safety evacuation plan) included the acronym R.A.C.E. (rescue, alarm, confine, extinguish and evacuate) and was very vague. No other documentation was provided. O/LALD-A stated that there has not been evacuation drills and fire safety and evacuation plan training for employees and residents since 2022. Emergency evacuation map was posted throughout the facility but did not show the location and number of resident rooms as well as where the emergency exits were. This was the case for all four houses on this campus.	{0 810}		
{0 820} SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by:	{0 820}		

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{0 820}	Continued From page 11 Based on observation and interview, the licensee failed to provide properly sized egress windows and door locking arrangements that did not constitute a distinct hazard to life. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On September 30, 2024, at 10:30 a.m., on a follow up survey, survey staff conducted a facility tour with owner/licensed assisted living director (O/LALD)-A. During facility tour, survey staff observed the following: Survey staff measured and verified egress window measurement of the openable area to be 23" high x 23.5" wide for a total of 540.5 square inches in occupied resident bedroom, unit#20-house #3. Survey staff measured and verified egress window measurement of the openable area to be 26" high x 23.5" wide for a total of 540.5 square inches in unoccupied resident bedroom, unit #21-house #3. Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height and width dimension of no less than 20". O/LALD-A verbally confirmed survey staff	{0 820}		

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{0 820}	Continued From page 12 observations during the facility tour. No further information provided.	{0 820}		

Electronically Delivered

July 25, 2024

Licensee
Comfort Care Cottages
1232 Jefferson Street South
Wadena, MN 56482

RE: Project Number(s) SL30454015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 2, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30454015 On July 1, 2024, through, July 2, 2024, 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 13 residents, 12 residents receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on July 2, 2024, issued for SL30454015-0, tag identification 0820. On July 7, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 100	Continued From page 1	0 100		
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with	0 100		

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0 100	Continued From page 2 dementia care license for a building that is on a campus and that is operating as an assisted living facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain accurate licensure when they applied for licensure under a single license for two or more buildings with mixed occupancy on a campus that was operated by the same licensee as an assisted living facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's health facility identification (HFID) 30454, a campus, consisted of four separate houses situated within walking distance of one another and was located on a corner lot. The campus consisted of: house #1 (1232 Jefferson Street South, Wadena, MN), house #2 (16 Lincoln Avenue Southeast, Wadena, MN), house #3 (20 Lincoln Avenue Southeast, Wadena, MN), and house #4 (1224 Jefferson Street South, Wadena, MN). On July 1, 2024, at 12:00 p.m., during the tour of the facility, clinical nurse supervisor (CNS)-B stated house #1 had 4 assisted living rooms	0 100		

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0 100	Continued From page 3 (capacity), and one assisted living room was occupied. CNS-B stated the front of the house and upstairs was a private residence where the owners lived and showed the surveyor a locked door that entered into the private living space. CNS-B did not allow access to private residence to the surveyor. On July 2, 2024, at 2:45 p.m., the surveyor toured the campus with owner/licensed assisted living director (O/LALD)-A. During the campus tour, the surveyor observed the following in house #1: -the surveyor observed house #1 had mixed occupancy of assisted living, and family members under the same roof, separated by a locked door, and it did not appear to have a two-hour fire separation wall. On July 2, 2024, at 5:00 p.m., O/LALD-A stated he had two older children that were currently living in the private living space in house #1. O/LALD-A stated he was not aware of the need to have a two-hour fire separation wall between private and assisted living spaces. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100		
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing	0 130		

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0 130	Continued From page 4 address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or	0 130		

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0 130	Continued From page 5 state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates	0 130		

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0 130	Continued From page 6 to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the	0 130		

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0 130	Continued From page 7 commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to meet the definition of an assisted living facility when the licensee had non-resident individual (unlicensed personnel (ULP)-E) residing at the facility. 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 the residents). The findings include: The licensee's assisted living licensure effective date was November 1, 2023, with an expiration date of October 31, 2024. On July 1, 2024, at 12:00 p.m., during the entrance tour of house #4, clinical nurse supervisor (CNS)-B stated the owner/licensed assisted living director (O/LALD)-A's wife (ULP-E) was currently staying downstairs in house #4. CNS-B stated when she was here filling in for other staff or doing things at the facility, she may sleep at the facility. CNS-B stated the bedroom was an empty resident room. On July 1, 2024, at 12:45 p.m., O/LALD-A stated his wife (ULP-E) is currently staying in the unoccupied bedroom downstairs in house #4 and sleeps there when she is helping or doing other duties around the campus. O/LALD-A stated	0 130		

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0 130	Continued From page 8 ULP-E does not have a written contract with the licensee and will have ULP-E remove her personal belongings from house #4 and no longer stay there. On July 2, 2024, at 2:45 p.m., O/LALD-A stated his wife was still occupying the bedroom in house #4. Minnesota Assisted Living Statutes 144G.08 definitions indicated: - Subd. 2. Adult - "Adult" means a natural person who has attained the age of eighteen years. - Subd. 5. Assisted living contract - "Assisted living contract" means the legal agreement between a resident and an assisted living facility for housing, and if applicable, assisted living services;" - Subd. 7. Assisted living facility - "Assisted living facility" means a facility that provides sleeping accommodations and assisted living services to one or more adults. Refer to clauses 1-15 for exclusions. - Subd. 59. Resident. - "Resident" means an adult living in an assisted living facility who has executed an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 130		
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;	0 470		

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	30454	A. BUILDING: _____ B. WING _____	07/02/2024

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COMFORT CARE COTTAGES	1232 JEFFERSON STREET SOUTH WADENA, MN 56482

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0 470	Continued From page 9 (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 470		

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0 470	Continued From page 10 The findings include: The licensee failed to develop and implement a staffing plan for determining its staffing level based on the following: -each resident's needs, as identified in the resident's service plan and assisted living contract; -each resident's acuity level, as determined by the most recent assessment or individualized review; -the ability of staff to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; and -whether the facility has a secured dementia care unit; and staff experience, training, and competency. The facility was licensed for a capacity of 21 residents and had a current census of 12 residents. On July 1, 2024, at 10:34 a.m., during the entrance conference, owner/licensed assisted living director (O/LALD)-A and clinical nurse supervisor (CNS)-C stated the licensee had not developed a staffing plan. O/LALD-A stated, "we will get cited for that" and he was not aware a staffing plan needed to be implemented. Additionally, O/LALD-A stated the usual staffing schedule for the facility was as follows: -one to two unlicensed personnel (ULP) day shift, one ULP evening and night shift; -registered nurse (RN) onsite Monday-Thursday, 10:00 a.m. to 4:00 p.m., but hours can vary and on call every other week; and -CNS onsite during the week approximately 15-20 hours a week and on call every other week.	0 470		

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0 470	Continued From page 11 Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective October 2022, the CNS must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 480		

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0 480	Continued From page 12 The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 2, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation interview and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all current residents, staff, and visitors.	0 550		

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0 550	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 1, 2024, at 12:00 p.m., the surveyor toured the campus with clinical nurse supervisor (CNS)-B. Surveyor and CNS-B observed a posted document with contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, Min-Minnesota Legal Aid/Minnesota Disability Law Center, Minnesota Department of Human Services and Senior Linkage Line; however, surveyor or CNS-B observed no posting of the facilities grievance procedure in any of the four houses on the campus. On July 2, 2024, at 5:25 p.m. owner/licensed assisted living director (O/LALD)-A stated a document is posted for residents with phone numbers should they want to file a complaint, and a grievance form is in a drawer in the nurses station to give to residents should they want one. O/LALD-A stated he thought he had the grievance procedure posted as well. The licensee's Complaint/Grievance policy dated December 19, 2023, indicated the policy is to ensure complaints regarding (facility) are resolved in a timely and appropriate manner for employee or residents that have concerns or complaints.	0 550		

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0 550	Continued From page 14 No further information was provided. TIME PERIOD OF CORRECTION: Twenty-One (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 580		

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0 580	Continued From page 15 the residents). The findings include: During the entrance conference on July 1, 2024, at 10:34 a.m., owner/licensed assisted living director (O/LALD)-A stated the licensee had no quality management plan, "it has gone by the wayside, last meeting was 2022 sometime." A quality management policy was requested during survey, but no policy was received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency number and	0 640		

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0 640	Continued From page 16 contact information for Minnesota Adult Abuse Reporting Center (MAARC) in common areas in any of the four houses on the campus. 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 July 1, 2024, at 12:00 p.m., the surveyor toured the campus with clinical nurse supervisor (CNS)-B. Surveyor and CNS-B observed no postings of the 911 emergency number or MAARC information in any of the four houses on the campus. On July 2, 2024, at 5:16 p.m. owner/licensed assisted living director (O/LALD)-A stated he thought these numbers were posted and sometimes residents take postings down. A vulnerable adult reporting policy was requested during survey, but no policy was received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		

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0 660	Continued From page 17	0 660		
0 660 SS=D	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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-D). 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	0 660		

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0 660	Continued From page 18 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility's Tuberculosis (TB) risk assessment was completed May 8, 2023, and was determined to be a low risk level. ULP-D was hired on July 14, 2023, to provide direct care services to the facility's residents. ULP-D's employee record included a TB symptom and screen, and step one of a two-step TST documented on July 18, 2023, however, employee file lacked the second TST test. On July 2, 2024, at 2:45 p.m., clinical nurse supervisor (CNS)-B stated she is sure an appointment was set up at the clinic for her second step, but she was unable to find ULP-D's second TST test. CNS-B stated she will need to check with ULP-D and would need to check with the clinic. The licensee's Tuberculosis Screening policy dated May 31, 2024, indicated new staff will have an Interferon Gamma Release Assay (IGRA) blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for healthcare workers (HCWs). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 19 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content, failed to post an emergency preparedness plan prominently and failed to review the missing resident policy quarterly. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 20 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 1, 2024, at 12:00 p.m., the surveyor toured the campus with clinical nurse supervisor (CNS)-B. The surveyor observed no signage posted or information regarding the licensee's emergency plan in any of the four houses. The licensee's undated Emergency Preparedness Manual included a generic fire, flooding, severe weather/tornado warning plans, a missing resident plan and diagrams of each house. The licensee's plan lacked the following content and/or policies and procedures to address: - an all-hazards approach risk assessment specific to the geographic location of the facility; - a comprehensive program to include other natural disasters, man-made disasters, facility based (power, water etc.), infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - the development of arrangements with other facilities and providers to receive residents if needed; - the facilities role in providing care and treatment at alternative sites; - the provision of subsistence needs for staff and	0 680		

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0 680	Continued From page 21 residents; - a tracking system used to document locations of residents and staff; - an evacuation plan; - how the facility would provide a means to shelter in place for residents and volunteers; and - the medical record documentation system the facility has developed to preserve resident information security and availability of records. In addition, the licensee lacked a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the emergency plan with residents and their families. On July 2, 2024, at 5:14 p.m., owner/licensed assisted living director (O/LALD-A) stated he was unaware the missing resident policy needed to be reviewed quarterly and the EPP annually. O/LALD-A stated the EPP was not complete and was aware it needed to be completed. The licensee's Emergency Preparedness policy dated May 31, 2024, indicated the [facility] will	0 680		

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0 680	Continued From page 22 develop and maintain a compliant fire safety an evacuation plan. The licensee's Missing Resident policy dated May 2, 2024, indicated the [facility] will review this policy and any individual plans that pertain to elopement at least quarterly, and all changes will be documented. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each	0 780		

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COMFORT CARE COTTAGES	1232 JEFFERSON STREET SOUTH WADENA, MN 56482

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0 780	Continued From page 23 separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected throughout the facility so that actuation of one alarm will cause all alarms in the dwelling to actuate. The licensee also failed to provide a smoke alarm in residents sleeping rooms. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 780		

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0 780	Continued From page 24 On a facility tour on July 02, 2024, at 2:30 p.m., with owner/licensed assisted living director (O/LALD)-A, survey staff observed that smoke alarms throughout the facility were not interconnected so that actuation of one alarm will cause all alarms in the dwelling to actuate. This was discovered when the O/LALD-A tested the smoke alarms in each of the four houses and they could not be heard throughout the facilities. House#1- Smoke alarms were missing in bedroom #10 and in the two bedrooms upstairs where the owners family is sleeping. House#2-The smoke alarm in bedroom #17 was not working. Smoke alarms should be provided in each sleeping room. O/LALD-A stated he would get these smoke alarms replaced as soon as possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide documentation of monthly inspections of all the fire extinguishers. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On July 02, 2024, survey staff conducted a facility tour with owner/licensed assisted living director (O/LALD)-A, survey staff observed that the fire extinguishers throughout the four houses at the facility did not have documentation of monthly inspections. Monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. O/LALD-A stated that he did not know they needed to be done. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 26 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to	0 810		

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0 810	Continued From page 27 conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on July 02, 2024, at 4:05 p.m. with owner/licensed assisted living director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the FSEP (fire safety evacuation plan) included the acronym R.A.C.E. (rescue, alarm, confine, extinguish and evacuate) and was very vague. No other documentation was provided. O/LALD-A stated that there has not been evacuation drills and fire safety and evacuation plan training for employees and residents since 2022. Emergency evacuation map was posted throughout the facility but did not show the location and number of resident rooms as well as where the emergency exits were. This was the case for all four houses on this campus. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment	0 820		

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0 820	Continued From page 28 (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide properly sized egress windows and door locking arrangements that did not constitute a distinct hazard to life. This had the potential to directly affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a 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: EGRESS WINDOWS On July 02, 2024, at 2:45 p.m., survey staff conducted a facility tour with Owner/licensed	0 820	This immediate correction order identified on July 2, 2024, has had the immediacy lifted as of July 7, 2024, however non-compliance remained a scope and level of I.	

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0 820	Continued From page 29 assisted living director (O/LALD)-A. During facility tour, the following issues were observed: In occupied resident bedroom, unit#20- house #3, survey staff measured and verified egress window measurement of the openable area to be 23" high x 23.5" wide for a total of 540.5 square inches. In unoccupied resident bedroom, unit #21- house #3, survey staff measured and verified egress window measurement of the openable area to be 26" high x 23.5" wide for a total of 540.5 square inches. Egress windows in existing facilities must have a minimum opening dimension of 648 square inches with an opening height dimension of no less than 20" and an opening width dimension of no less than 20". EXIT DOOR LOCKING On July 02, 2024, at 2:30 p.m., survey staff toured the facility with O/LALD-A. During the facility tour in House #2, survey staff observed the facility main front exit door was locked from the inside of the facility and required a key to unlock the door. Per MN State Fire Code, all means of egress must be maintained and able to operate without special knowledge, key, or tool. O/LALD-A verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	0 820		

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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 according to manufacturer's instructions for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's Humalog Kwikpen insulin was not administered per manufacturer's instructions. R1's diagnoses included diabetes, chronic kidney	01760		

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01760	Continued From page 31 disease, and hypertension (high blood pressure). R1's Master Care Plan indicated R1 received medication management services to include medication administration and needs help with injectable medications, staff set up injection pens with the amount needed and resident checks the amount and injects himself. R1's prescriber orders dated May 21, 2024, included an order for Humalog Kwikpen insulin, 6 units, three times daily with meals, and the below sliding scale with meals (a scale directing the amount of insulin that should be administered based off the blood glucose [sugar] result): - 111 - 150 = administer 4 units; - 151 - 200 = administer 6 units; - 201 - 250 = administer 8 units; - 251 - 300 = administer 12 units; - 301 - 350 = administer 14 units; - 351 - 400 = administer 16 units; and - greater than 401 = administer 16 units. Max insulin dose is 75 units. On July 2, 2024, at 7:30 a.m., in the kitchen/medication cupboard area, the surveyor observed unlicensed personnel (ULP)-D use appropriate technique to conduct a blood glucose check on R1, which resulted in a reading of 200 milligrams (mg)/deciliter (dL). ULP-D looked at electronic medication administration record and stated, "will need an additional 8 units". Surveyor intervened and asked if that was correct, and how much additional sliding scale Humalog insulin she would be giving. ULP-D looked again and stated, "Oh, 6 more units, not 8." ULP-D then proceeded to place the needle on the multi-dose insulin pen without properly cleaning the hub of the insulin pen with an alcohol wipe prior to attaching the needle. ULP-D then dialed the insulin pen to 12	01760		

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01760	Continued From page 32 units (scheduled 6 units and 6 units of sliding scale) and handed it to R1. Surveyor intervened and asked ULP-D if she was missing any steps, and she stated, "No, my husband is diabetic, and I help him at home too". ULP-D handed the uncapped Lispro insulin pen to R1. R1 verified pen was dialed to 12 units lifted his shirt and self-administered to left side of abdomen. Surveyor did not observe ULP-D prime the insulin pen, prior to dialing up to 12 units dose or use alcohol wipe to cleanse the injection site. ULP-D then disposed needle in sharps container, replaced cap on pen, used alcohol pad to sanitize glucometer and put back in case. On July 2, 2024, at 7:50 a.m., ULP-D stated she forgot to alcohol the hub of the insulin pen and injection site, as well as prime the insulin pen with 2 units prior to dialing to the 12 units. ULP-D stated she was trained on using insulin pens by the registered nurses (RN). ULP-D stated her training consisted of watching videos, worked side by side with an RN, then shadowed another ULP one day, then worked side by side with another ULP a day, then was on her own. On July 2, 2024, at 2:50 p.m., clinical nurse supervisor (CNS)-B stated the ULPs are taught to alcohol the hub and prime with 2 units and cleanse the injection site. They are taught this in training with the RN. CNS-B stated she will need to be retrained right away. ULP-D's insulin pen competency training dated and signed by RN and ULP-D on July 27, 2023, indicated to remove the pen cap and clean with an alcohol wipe, prime the pen per manufacturer instructions, and clean the alternating injection site with alcohol wipe or soap and water.	01760		

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01760	Continued From page 33 The manufacturer's instructions for the use of Humalog Kwikpen insulin, dated March 2020, directed for the insulin pen to wipe the rubber seal with an alcohol swab, turn the dose knob to two units to prime prior to dialing the prescribed dosage. If not completed before each injection, too much or too little insulin may be administered. The licensee's Insulin policy dated May 31, 2024, noted insulin medications must be administered according to the prescriber's orders, however, did not include directions regarding insulin pens and administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures. 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	01880		

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01880	Continued From page 34 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 1, 2024, at 10:34 a.m., during the entrance conference, owner/licensed assisted living director (O/LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the licensee's residents including medications storage. On July 1, 2024, at 12:20 p.m., the surveyor observed the medication refrigerator with CNS-B. The refrigerator had one internal thermometer, indicating 38 degrees Fahrenheit (F). CNS-B stated the morning shift staff were responsible for monitoring and recording daily medication refrigerator temperatures. CNS-B verified the refrigerator temperature log lacked daily monitoring of temperatures and verified the following medications were being stored: -one (1) unopened Lantus SoloStar (long-acting insulin) pen; and -three (3) unopened Humalog Kwikpen (fast acting insulin). The refrigerator temperature monitoring flow sheet indicated from May 24, 2024 through June 30, 2024, twelve temperature monitoring days were not documented. The manufacturer's instructions for Lantus SoloStar insulin pen dated June 2022, indicated before opening store the insulin pens in the refrigerator 36-46 degrees F. Do not allow the	01880		

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01880	Continued From page 35 Lantus to freeze. The manufacturer's instructions for Humalog Kwikpen insulin dated March 2022, indicated unopened insulin should be stored in a refrigerator 36-46-degrees F and not to use if had been frozen. The licensee's Medication Storage policy dated May 30, 2024, indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 not used beyond the expiration date for two of two residents (R3, R4), and failed to ensure medications maintained bearing the original prescription label with legible information for two of two residents (R4, R5), and failed to ensure medications maintained bearing the original	01890		

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COMFORT CARE COTTAGES	1232 JEFFERSON STREET SOUTH WADENA, MN 56482

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01890	Continued From page 36 prescription label with legible information including the expiration date for time sensitive medications for one of one resident (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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 1, 2024, at 12:00 p.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-B, including a review of the locked medication room cupboard in house #2. The surveyor observed and confirmed the following with CNS-B: EXPIRED MEDICATIONS R3 -acetaminophen 500 milligram (mg) tablets (for pain), take 2 tablets by mouth every 6 hours as needed. Expiration date: May 5, 2024 -nitroglycerin 0.4 mg (treats chest pain), take 1 tablet as directed. Discard date: April 18, 2024. R4 -hydrocortisone cream 1% (treats skin conditions). Expiration date: November 2023. ORIGINAL PRESCRIPTION LABELS R4 R4's hydrocortisone cream 1% lacked an original prescription label with information regarding the directions for use, resident's name, the pharmacy in which it had been issued. R5	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30454	A. BUILDING: _____ B. WING _____	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT CARE COTTAGES	1232 JEFFERSON STREET SOUTH WADENA, MN 56482

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01890	Continued From page 37 R5's two separate Advair HFA 115 micrograms (mcg)/21 mcg inhalers (treats chronic pulmonary disease) lacked original prescription labels with information regarding the directions for use, resident's name, the pharmacy in which it had been issued. ORIGINAL PRESCRIPTION LABELS/TIME SENSITIVE MEDICATIONS R6 R6's Azelastine HCL eyedrop (for allergies) lacked an original prescription label with information regarding the directions for use, resident's name, the pharmacy in which it had been issued, and the date the eye drop had been opened and expiration date. On July 1, 2024, at 12:16 p.m., CNS-B stated there should not be expired medications in medication cupboard, all medication should be labeled appropriately, and any time sensitive medications should have open and expiration dates. CNS-B stated the nurses will need to start to do audits on the medication cupboards. The manufacturer's instructions for Azelastine hydrochloride eye drops, dated December 2012, indicated once the bottle is open, do not use it for longer than 4 weeks even if there is some left in the bottle after this time. The licensee's Storage of Medications policy dated May 5, 2024, did not address expired medications, original prescription labels, or time sensitive medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30454	A. BUILDING: _____ B. WING _____	07/02/2024

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02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure privacy was maintained for one of one resident (R1) observed during a blood glucose monitoring and insulin administration procedure. 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	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30454	A. BUILDING: _____ B. WING _____	07/02/2024

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02410	Continued From page 39 cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's prescriber orders dated May 21, 2024, included an order for blood glucose monitoring and insulin administration to be completed four times a day. On July 2, 2024, at 7:30 a.m., R1 was seated in the kitchen/medication cupboard area. There was residents walking by the area and one resident standing and visiting with R1 while waiting for his medications. Prior to sitting down, R1 washed his hands. The surveyor observed unlicensed personnel (ULP)-D wash hands, donned with gloves and use appropriate technique to conduct a blood glucose check on R1. ULP-D placed needle on the insulin pen, then dialed the insulin pen to 12 units and handed it to R1. R1 verified pen was dialed to 12 units lifted his shirt and self-administered to left side of abdomen. ULP-D did not encourage, offer, or attempt to direct R1 to a private area to perform the blood glucose monitoring procedure or to have him self-administer his insulin. On July 2, 2024, at 7:50 a.m., the ULP-D stated R1 doesn't mind doing his blood glucose and insulin here. On July 2, 2024, at 2:52 p.m., clinical nurse supervisor (CNS)-B confirmed blood glucose monitoring procedures and administration of an injectable medication should be done in a private area, staff are taught to take R1 around the	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02410	Continued From page 40 corner to the bathroom for privacy. The licensee's Insulin policy dated May 31, 2024, indicated to provide privacy for the individual prior to blood glucose check and insulin administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *07/02/24*
Time: 14:14:42
Report: 7935241023

Food and Beverage Establishment Inspection Report

Location:
Comfort Care Cottages
1232 Jefferson Street South
Wadena, MN56482
Wadena County, 80

Establishment Info:
ID #: 0038253
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2186314873
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.

7-200 Toxic Supplies and Applications

7-204.11 ***** Priority 1 *****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

SCENTED CHLOROX WIPES ARE NOT APPROVED FOR FOOD CONTACT SURFACES. OWNER WENT TO GET AN APPROVED SANITIZER FROM THE STORE DURING INSPECTION.

Comply By: 07/02/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

CERTIFICATION EXPIRED ON 06/12/24. NEW COURSE WORK HAS BEEN COMPLETED AND RENEWAL APPLICATION HAS BEEN MAILED IN. INSPECTOR WILL WATCH FOR THIS TO BE RECEIVED.

Comply By: 07/31/24

Surface and Equipment Sanitizers

Hot Water: = at 165 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *07/02/24*
Time: 14:14:42
Report: 7935241023
Comfort Care Cottages

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Hoshizaki Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Artic Air
Violation Issued: No

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

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

I acknowledge receipt of the MN Department of Health inspection report number 7935241023 of 07/02/24.

Certified Food Protection Manager: Teresa Erickson

Certification Number: 19689 Expires: 06/12/24

Signed: _____
Establishment Representative

Signed: _____
Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us