DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 31, 2022

Administrator
Garden House Estates, Ltd.
1 Riverside Drive
Duluth, MN 55808

RE: Project Number(s) SL30814015

Dear Administrator:

On March 22, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on October 20, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the October 20, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 20, 2021, found not corrected at the time of the March 22, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on March 22, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

authorized in §144G.20.

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

REQUESTING A HEARING

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

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

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at (651) 201-3993.

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

Sincerely,

Jessica Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55164-0970 / 55101-3879
Telephone: 651-508-2791 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30814	A. BUILDING: _____ B. WING _____	R 03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN HOUSE ESTATES LTD	1 RIVERSIDE DRIVE DULUTH, MN 55808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL30814015 On March 22, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 20, 2020. At the time of the survey, there were 22 residents; 22 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.	{0 660}		

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{0 660}	Continued From page 2 (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure a history and symptoms screening for two of two employees (unlicensed personnel (ULP)-C and licensed practical nurse (LPN)-F with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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: ULP-C ULP-C started employment on September 13, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021, under the assisted living license. R3's March 2022, medication administration record indicated ULP-C administered medication to R3 on several occasions. ULP-C's employee record lacked evidence of a TB history and symptom screen.	{0 660}		

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{0 660}	Continued From page 3 LPN-F LPN-F began providing assisted living services on February 1, 2022. On March 22, 2022, at approximately 10:30 a.m., the surveyor observed LPN-F provide direct care services to residents. On March 22, 2022, at approximately 12:10 p.m., registered nurse (RN)-A confirmed ULP-C and LPN-F's employee records lacked a TB history and symptom screening. The licensee's 8.16 Tuberculosis Screening policy, dated December 1, 2021, indicated staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided.	{0 660}		

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{0 730}	Continued From page 4	{0 730}		
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	{0 730}		

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{0 730}	Continued From page 5 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record contained documentation of the services being provided for one of three residents (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's Service Plan dated February 22, 2022, indicated services included medication administration; assistance with bathing once a week; morning (AM) and evening (PM) care; laundry provided weekly; and housekeeping provided weekly. R3's Resident Service Record for March 2022 indicated the ULP documented the services provided as follows:	{0 730}		

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{0 730}	Continued From page 6 -bathing one out of three opportunities; -AM and PM cares three (3) out of forty-four (44) opportunities; -laundry one out of three opportunities; and -housekeeping zero out of three opportunities. On March 22, 2022, at approximately 12:10 p.m., registered nurse (RN)-A confirmed R3's records lacked documentation of the services provided as written on the residents' service plans. RN-A stated a lack of documentation of services provided continues to be a problem. The licensee's 2.38 Resident Record-Information and Content policy, dated December 1, 2021, indicated the resident record must contain documentation that services identified on the resident's service plan have been completed. No further documentation was provided.	{0 730}		
{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	{0 780}		

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{0 780}	Continued From page 7 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: No further action required.	{0 780}		
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee	{01530}		

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{01530}	Continued From page 8 until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure two of three employees (registered nurse (RN)-A and licensed practical nurse (LPN)-F) received the required amount of dementia care training in the required time frame with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-A RN-A started employment on May 31, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021, under the assisted living license. On March 22, 2022, throughout the survey, the surveyor observed RN-A supervise ULP. RN-A's employee record indicated RN-A completed 2.5 hours of the required eight (8) hours of dementia training. LPN-F	{01530}		

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{01530}	Continued From page 9 LPN-F began providing assisted living services on February 1, 2022. On March 22, 2022, at approximately 10:30 a.m., the surveyor observed LPN-F provide direct care services to residents. LPN-F's employee record indicated LPN-F completed 6.5 of the required eight (8) hours of dementia training. On March 22, 2022, at approximately 12:15 p.m. RN-A confirmed RN-A and LPN-F had not completed the required eight (8) hours of dementia training. The licensee's 5.03 Dementia Training policy dated December 1, 2021, indicated, all staff of Garden House Estates are required to complete dementia training at the time of hire. Supervisors of direct care staff will complete eight (8) hours of initial training within 120 hours of the employment start date and direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. No further information was provided.	{01530}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

PENALTY AMENDED MAY 16, 2022 PER REVIEW
TAG 0640 DELETED - PENALTIES $3,500

Electronically Delivered

February 2, 2022

Administrator
Garden House Estates, LTD
1 Riverside Drive
Duluth, MN 55808

RE: Project Number(s) SL30814015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on January 24, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements = $500.00
St - 0 - 0480 - 144g.41 Subd 1 (13) (i) (b) - Minimum Requirements = $500.00
St - 0 - 0580 - 144g.42 Subd. 2 - Quality Management = $500.00
~~**St - 0 - 0640 - 144g.42 Subd. 7 - Posting Information For Reporting Suspected C = $500.00**~~
St - 0 - 0660 - 144g.42 Subd. 9 - Tuberculosis Prevention And Control = $500.00
St - 0 - 0680 - 144g.42 Subd. 10 - Disaster Planning And Emergency Preparedness = $500.00
St - 0 - 0900 - 144g.50 Subdivision 1 - Contract Required = $500.00
St - 0 - 1790 - 144g.71 Subd. 10 - Medication Management For Residents Who Will = $500.00

The total amount you are assessed is $3,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on January 24, 2022, we identified the following violation(s):

1640-Service Plan, Implementation, And Revisions T-144g.70 Subd. 4

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

Sincerely,

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

Electronically Delivered

February 2, 2022

Administrator
Garden House Estates, LTD
1 Riverside Drive
Duluth, MN 55808

RE: Project Number(s) SL30814015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on January 24, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements = $500.00
St - 0 - 0480 - 144g.41 Subd 1 (13) (i) (b) - Minimum Requirements = $500.00
St - 0 - 0580 - 144g.42 Subd. 2 - Quality Management = $500.00
St - 0 - 0640 - 144g.42 Subd. 7 - Posting Information For Reporting Suspected C = $500.00
St - 0 - 0660 - 144g.42 Subd. 9 - Tuberculosis Prevention And Control = $500.00
St - 0 - 0680 - 144g.42 Subd. 10 - Disaster Planning And Emergency Preparedness = $500.00
St - 0 - 0900 - 144g.50 Subdivision 1 - Contract Required = $500.00
St - 0 - 1790 - 144g.71 Subd. 10 - Medication Management For Residents Who Will = $500.00

The total amount you are assessed is $4,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on January 24, 2022, we identified the following violation(s):

1640-Service Plan, Implementation, And Revisions T-144g.70 Subd. 4

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

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

Please address your cover letter for general reconsideration requests to:
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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.

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	30814	A. BUILDING: _____ B. WING _____	R 01/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN HOUSE ESTATES LTD	1 RIVERSIDE DRIVE DULUTH, MN 55808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL30814015-1 On January 24, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 20, 2021. At the time of the survey, there were 22 active residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 430} SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	{0 430}		

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{0 430}	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the uniform checklist of disclosure of services was provided to three of three residents (R2, R3 and R6) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a 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:	{0 430}		

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{0 430}	Continued From page 2	{0 430}		

R2
R2, R3 and R6's records lacked a uniform checklist disclosure of services to include:
- a disclosure of the categories of assisted living licenses available and the category of license held by the facility;
- a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and
- an oral explanation of all services offered under the contract.

R2's Service Plan dated July 22, 2021, indicated services included medication administration, assistance with shower, dressing as needed, and cleaning of a CPAP (continuous positive airway pressure) machine daily.

R3
R3's Service Plan dated December 19, 2017, indicated services included medication administration and assistance with bathing, grooming, incontinent care, laundry and housekeeping.

R6
R6 was admitted for services on November 22, 2021. R6's record indicated R6 received assistance with medication administration, laundry and housekeeping. R6's record lacked evidence a service plan had been developed.

On January 24, 2022, at approximately 9:00 a.m., during the entrance conference, registered nurse (RN)-A confirmed R2, R3, R6, and all other residents receiving services under the licensee's Assisted Living License had not received the

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{0 430}	Continued From page 3 uniform checklist disclosure of services. RN-A provided the surveyor a uniform checklist disclosure of services that was partially filled in. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided.	{0 430}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and	{0 470}		

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{0 470}	Continued From page 4 (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the staffing plan was developed and posted as required, potentially affecting all twenty-two (22) residents in the assisted living facility, staff and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee 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.	{0 470}		

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{0 470}	Continued From page 5 On January 24, 2021, at approximately 9:00 a.m., during the entrance conference, registered nurse (RN)-A confirmed the licensee had not developed a staffing plan to address the content listed above. RN-A stated a staffing schedule was posted on the nursing office door that indicated what staff person was working each shift. RN-A stated the staffing schedule posted was not based on each resident's needs, acuity level, or the ability of staff to timely meet the resident's schedule. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided.	{0 470}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	{0 480}		

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{0 480}	Continued From page 6 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 had the potential to affect all twenty-two (22) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 24, 2022, for the specific Minnesota Food Code deficiencies.	{0 480}		
{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	{0 580}		

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{0 580}	Continued From page 7 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 a quality management activity. This had the potential to affect all twenty-two (22) 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, 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 January 24, 2022, at approximately 9:00 a.m., during the entrance conference, registered nurse (RN)-A stated the licensee had not developed a quality management program and there was no current documentation of a quality management activity. The licensee's Quality Improvement Project policy, dated January 1, 2019, indicated the licensee would have at least one documented quality improvement project in place at all times and retain records of such projects for at least two years. No further information was provided.	{0 580}		

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{0 660}	Continued From page 8	{0 660}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure a history and symptoms screening and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for two of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-C) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive	{0 660}		

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{0 660}	Continued From page 9 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-A, and ULP-C's employee records lacked evidence of a completed health history and symptom screening, including completion of a two-step TST or other evidence of TB screening, such as a blood test. RN-A started employment on May 31, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On January 24, 2022, the surveyor observed RN-A providing direct care to residents and supervision to ULP's. RN-A's employee record lacked evidence a TB history and symptom screen had been completed. ULP-C started employment on September 13, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On January 24, 2022, at approximately 11:00 a.m., RN-A stated ULP-C worked the night shift providing direct care. ULP-C's employee record lacked evidence a TB history and symptom screen and a two-step TST had been completed. On January 24, 2022, at approximately 12:10 p.m., RN-A confirmed RN-A and ULP-C's employee records lacked a TB history and	{0 660}		

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{0 660}	Continued From page 10 symptom and/or a two-step TST. The licensee's Tuberculosis and Staff Screening policy dated January 1, 2021, indicated the licensee shall complete a written community TB Risk Assessment. Employees shall be screened and test for TB prior before staff being exposed to clients [residents.] The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided.	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	{0 680}		

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{0 680}	Continued From page 11 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency disaster plan with all required content and failed to post an emergency plan prominently. 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: During the entrance conference on January 24,	{0 680}		

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{0 680}	Continued From page 12 2022, at approximately 9:00 a.m. registered nurse-A stated the licensee's written disaster plan was a work in progress. On January 24, 2022, at approximately 9:00 a.m., RN-A confirmed the licensee did not have an emergency preparedness plan that included the following required content: -a risk assessment for the facility; - a comprehensive program to include 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; - procedure for tracking staff and residents; and - subsistence needs for staff and residents during emergency situation. - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies; and - the facility's role in providing care and treatment at alternative sites. - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management	{0 680}		

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{0 680}	Continued From page 13 agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -a method of sharing information from the emergency plan with residents and their families. - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. A policy was requested, but not provided. No further information was provided.	{0 680}		
{0 730} SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or	{0 730}		

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{0 730}	Continued From page 14 conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record contained documentation of the services being provided for two of two residents (R2, and R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	{0 730}		

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{0 730}	Continued From page 15 cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 and R3's records lacked documentation of the services being provided by the licensee. R2 R2's Service Plan dated July 22, 2021, indicated services included medication administration, assistance with showers, dressing as needed, personal laundry one time a week and PRN (as necessary), and housekeeping/linen change one time a week. R2's Resident Service Record for January 2022 indicated the unlicensed personnel (ULP) documented weekly laundry two of three opportunities. R3 R3's Service Plan dated December 19, 2017, indicated services included medication administration; assistance with bathing two times a week; grooming assistance two times a day; laundry provided weekly; and housekeeping provided weekly. R3's Resident Service Record for January 2022 indicated the ULP documented the services provided as follows: -bathing two out of six opportunities; -grooming assistance once out of forty-six (46) opportunities; -laundry zero out of three opportunities; and	{0 730}		

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{0 730}	Continued From page 16 -housekeeping one out of three opportunities. On January 24, 2022, at approximately 12:10 p.m., registered nurse (RN)-A confirmed R2, and R3's records lacked documentation of the services provided as written on the residents' service plans. RN-A stated a lack of documentation of services provided continues to be a problem. The licensee's Client Record-Outline policy dated January 1, 2021, indicated the resident's record must include documentation that services have been provided as identified in the service plan. No further documentation was provided.	{0 730}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to	{0 780}		

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{0 780}	Continued From page 17 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: No further action required	{0 780}		
{0 900} SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the	{0 900}		

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{0 900}	Continued From page 18	{0 900}		

contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.

(f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.

This MN Requirement is not met as evidenced by:
Based on interview, and record review, the licensee failed to execute an assisted living contract to include all required content for three of three residents (R2, R3 and R6) 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R2, R3, and R6's records lacked a written contract with the following required content:
(a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.
(b) The contract must contain all the terms concerning the provision of:
(1) housing;
(2) assisted living services, whether provided

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{0 900}	Continued From page 19	{0 900}		

directly by the facility or by management agreement or other agreement; and
(3) the resident's service plan, if applicable.
(c) A facility must:
(1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and
(2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments to the resident promptly after a contract and any addendum has been signed.
(d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.
(e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.
(f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.

R2
R2's Service Plan dated July 22, 2021, indicated services included medication administration, assistance with shower, dressing as needed, and cleaning of a CPAP (continuous positive airway pressure) machine daily.

R3
R3's Service Plan dated December 19, 2017, indicated services included medication administration assistance with bathing, grooming, incontinence care, laundry and housekeeping.

R6
R6 was admitted for services on November 22, 2021. R6's record indicated R6 received

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{0 900}	Continued From page 20 assistance with medication administration, laundry and housekeeping. R6's record lacked evidence a service plan had been developed. On January 24, 2022, at approximately 9:00 a.m., during the entrance conference registered nurse (RN)-A confirmed the licensee had not developed or implemented an assisted living contract for R2, R3, R6, and all other residents receiving services under the licensee's Assisted Living License. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided.	{0 900}		
{01370} SS=E	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls;	{01370}		

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{01370}	Continued From page 21 (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure training and competency evaluations contained all the requirements for two of two employees (unlicensed personnel (ULP)-C and ULP-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	{01370}		

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{01370}	Continued From page 22 The findings include: ULP-C and ULP-D's employee records lacked evidence the ULPs demonstrated competency in all the required topics. ULP-C started employment on September 13, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. R3's January 2022 medication administration record (MAR) indicated ULP-C administered medications to R3. ULP-C's employee record lacked evidence she demonstrated competency in the following areas: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting. ULP-D started employment on July 17, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On January 24, 2022, at approximately 11:00 a.m., registered nurse (RN)-A stated ULP-D provided direct care services to residents. ULP-D's employee record lacked evidence she demonstrated competency in the following areas: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and	{01370}		

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{01370}	Continued From page 23 - dressing and assisting with toileting. On January 24, at approximately, 12:10 p.m., RN-A confirmed ULP-C and ULP-D's employee records lacked evidence they received training and competency evaluations in the areas identified above. RN-A stated it was on her list of things to do. The licensee's Training and Competency Training policy dated January 1, 2021, indicated ULPs would be trained and demonstrate competency in the following areas: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting. No further information provided.	{01370}		
{01380} SS=E	144G.61 Subd. 2 Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation;	{01380}		

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{01380}	Continued From page 24 (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview, and record review the licensee failed to ensure training and competency evaluations contained all the required training for two of two employees (unlicensed personnel (ULP)-C and ULP-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C and ULP-D's employee records lacked evidence the ULPs demonstrated competency in all the required topics. ULP-C started employment on September 13, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. R3's January 2022 medication administration record (MAR) indicated ULP-C administered medications to R3. ULP-C's employee record lacked evidence she demonstrated competency in the following areas:	{01380}		

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{01380}	Continued From page 25 -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motion and positioning. ULP-D started employment on July 17, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On January 24, 2022, at approximately 11:00 a.m., registered nurse (RN)-A state ULP-D provided direct care services to residents. ULP-D's employee record lacked evidence she demonstrated competency in the following areas: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motion and positioning. On January 24, at approximately, 12:10 p.m., RN-A confirmed ULP-C and ULP-D's employee records lacked evidence they received training and competency evaluations in the areas identified above. RN-A stated it was on her list of things to do. The licensee's Training and Competency Training policy dated January 1, 2021, indicated ULPs would be trained and demonstrate competency in the following areas: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motion and position. No further information was provided.	{01380}		

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{01470}	Continued From page 26	{01470}		
{01470} SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any	{01470}		

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{01470}	Continued From page 27 training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations for one of three employees (registered nurse (RN)-A) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-A's employee record lacked evidence to indicate the employee received orientation to	{01470}		

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{01470}	Continued From page 28 include the following topics: - an overview of this chapter; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. RN-A started employment on May 31, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On January 24, 2022, the surveyor observed RN-A providing direct care to residents and supervision to ULP's. On January 24, 2022, at approximately 1:00 p.m., RN-A stated she had not completed the above identified training. RN-A stated she is working on updating all policies. No further information was provided.	{01470}		
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics	{01530}		

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{01530}	Continued From page 29	{01530}		

specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure one of three employees (registered nurse (RN)-A) received the required amount of dementia care training in the required time frame with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).
The findings include:
RN-A started employment on May 31, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

On January 24, 2022, the surveyor observed

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{01530}	Continued From page 30 RN-A providing direct care to residents and supervision to ULP's. RN-A's record indicated RN-A received the following training: -interview and overview; -communication: -activities of daily living; -behaviors various symptoms; and -the journey. RN-A's employee records lacked the number of dementia training hours RN-A had completed. Thus, it could not be determined if RN-A had completed the required eight hours of dementia training. On January 24, 2022, at approximately 1:00 p.m., RN-A stated she had not completed the eight hours of required dementia training. The licensee's Alzheimer's Disease and Related Disorder Training and Notification policy dated January 1, 2019, indicated the licensee would provide the required training. No further information was provided.	{01530}		
{01620} SS=E	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	{01620}		

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{01620}	Continued From page 31 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool on day 90 for two of two residents (R2 and R3) and the licensee failed to ensure the RN completed an initial assessment and 14-day reassessment and monitoring using the uniform assessment tool for one for one resident (R6) as required with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	{01620}		

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{01620}	Continued From page 32 The findings include: R2 R2's record lacked evidence a 90-day reassessment was completed using the using the uniform assessment tool. R2's Service Plan dated July 22, 2021, indicated services included medication administration, assistance with shower, dressing as needed, personal laundry one time a week and PRN (as necessary), and housekeeping/linen change one time a week. R2's record included a Monitoring and Reassessment dated October 4, 2021. R2's record lacked a 90-day reassessment, which was due on January 2, 2022. R3 R3's record lacked evidence a reassessment was completed every 90-days using the uniform assessment tool. R3's Service Plan dated December 19, 2017, indicated services included medication administration assistance with bathing two times a week; grooming assistance two times a day; laundry provided weekly; and housekeeping provided weekly. R3's record included a Monitoring and Reassessment for a 90-day visit dated June 28, 2021. R3's record lacked a 90-day assessment, which was due on September 28, 2021, and December 28, 2021. R6 R6's record lacked a initial assessment that	{01620}		

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{01620}	Continued From page 33 include all the required elements on the uniform assessment tool and lacked evidence a 14-day reassessment had been completed. R6's record lacked evidence a service plan had been developed. R6's January 2022, MAR indicated R6 received assistance with medication administration. R6's record included an initial assessment dated November 22, 2021. The assessment did not include all the required elements on the uniform assessment tool. R6's record lacked evidence a 14-day reassessment had been completed. On January 24, 2022, at approximately 1:00 p.m., RN-A confirmed R2, R3, and R6's assessments were not completed as stated above using the uniform assessment tool. RN-A showed the surveyor a copy of a blank uniform assessment tool that included all the required elements. RN-A stated the licensee was in the process of hiring a licensed practical nurse (LPN), so RN-A would have more time to do the required assessments. The licensee's Assessment Schedule policy dated January 1, 2021, indicated ongoing resident monitoring and reassessment must conducted no more than 14 days after initiation of services and be done at least every 90 days. The policy did not address the use of a uniform assessment tool. No further information was provided.	{01620}		

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01640	Continued From page 34	01640		
01640 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a service plan no later than 14 calendar days after the date services were first provided for one of one resident (R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01640		

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01640	Continued From page 35 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: R6 was a admitted for services on November 22, 2021. R6's initial assessment dated November 22, 2021, indicated R6 received assistance with medication administration, laundry, housekeeping, and three meals a day. R6's January 2022, medication administration record (MAR) indicated R6 received assistance with medication administration. R6's January 2022, Resident Services Record indicated R6 received assistance with laundry. R6's record lacked evidence the licensee had developed a service plan. On January 24, 2022, at approximately 12:10 p.m. registered nurse (RN)-A confirmed R6 did not have a service plan. The licensee's Service Plans policy dated January 1, 2021, indicated a service plan would be developed no later than 14 calendar days after the date of services were first provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
{01650} SS=B	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring	{01650}		

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{01650}	Continued From page 36 assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plans included all the required content for two of two residents (R2, and R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include:	{01650}		

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{01650}	Continued From page 37 R2 R2, and R3's service plans lacked the fees for services. R2's January 2022, medication administration record (MAR) indicated R2 received assistance with medication administration. R2's January 2022, Resident Services Record indicated R2 received assistance with laundry, housekeeping and three meals a day. R2's Service Plan dated July 22, 2021, lacked the fees for service. R3 R3's January 2022 MAR indicated R3 received assistance with medication administration. R3's January 2022, Resident Services Record indicated R3 received assistance with shower, hygiene, dressing, laundry, housekeeping, and three meals a day. R3's Service Plan dated December 19, 2017, lacked the fees for service. On January 24, 2022, at approximately 9:00 a.m., registered nurse (RN)-A confirmed R2, and R3's service plans were incomplete and did not include the above noted content. RN-A stated she is working with the owner on incorporating the fees into the service plan. The licensee's Service Plans policy January 1, 2021, noted the service plan would include, but was not limited to, the fees for services. No further information was provided.	{01650}		

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{01750}	Continued From page 38	{01750}		
{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks, the registered nurse (RN) trained the unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident, and failed to ensure the ULP demonstrated the ability to competently follow the procedure to perform the tasks for one of two employees (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	{01750}		

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{01750}	Continued From page 39 ULP-C started employment on September 13, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. R3's January 2022 medication administration record (MAR) indicated ULP-C administered oral medications to R3. R5's January 2022 MAR indicated ULP-C administered oral medications and insulin pens infections to R5. ULP-C's employee record lacked evidence the RN trained her or that ULP-C demonstrated competency for the administration of oral medications and insulin pens. On January 24, 2022, at approximately 1:00 p.m., registered nurse (RN)-A confirmed ULP-C's record lacked documentation of the training as indicated above. The licensee's Delegated Nursing Services policy, dated January 1, 2019, indicated the RN may delegate nursing services to the ULP after the ULP is trained and competent. Written instructions for performing the procedure for the client in the client's record. No further information was provided.	{01750}		
{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	{01760}		

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{01760}	Continued From page 40	{01760}		

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 interview, and record review, the licensee failed to ensure the effectiveness of PRN (as necessary) medications was documented for one of one resident (R3), and failed to ensure medications were documented as administered after administration.

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

The findings include:

R3's record lacked documentation of effectiveness of PRN medications.

R3's service plan dated December 19, 2017, indicated services included medication administration.

R3's prescriber's orders dated August 30, 2021,

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{01760}	Continued From page 41 included acetaminophen two tablets, 650 mg (milligrams) at bed time as needed for pain and Robafen 200/10 ml (milliliters) every four hours as needed for cough. R3's medication administration record (MAR) for January 2022 indicated the following: -acetaminophen two tablets, 650 mg, 23 out of 23 times administered, no effectiveness was documented; and -Robafen 200/10 ml, 23 out of 23 times administered, no effectiveness was documented. On January 24, 2022, at approximately 12:10 p.m., registered nurse (RN)-A confirmed staff had not documented the effectiveness of PRN medications administered to R3. The licensee's Medication Administration Policy dated January 1, 2019, indicated staff must document a follow-up for PRN medication administration within 60 minutes of administration. No further information provided.	{01760}		
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and	{01790}		

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{01790}	Continued From page 42 (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the	{01790}		

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{01790}	Continued From page 43 completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for medication management when residents had unplanned time away from home; and the licensee failed to ensure two of two unlicensed personnel (ULP-C and ULP-D) were trained and demonstrated competency to prepare and give medications for residents having unplanned time away. 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: During the entrance conference on January 24, 2022, at approximately 9:00 a.m., RN-A confirmed the licensee provided medication management services to a majority of residents at the facility, and ULP would prepare and send medications with the residents for unplanned times away.	{01790}		

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{01790}	Continued From page 44 The licensee failed to develop and implement a written procedure for ULP providing medications for residents having unplanned times away. The licensee's policy, Medications For A Client Who Will Be Away From Home When Medications Are Scheduled, dated January 1, 2019, indicated for situations when there would be a short-term absence that was not known in advance and a licensed nurse was not available, the RN may delegate the task to ULP. The RN would develop written procedures for the ULP to follow. The licensee's policy lacked a written procedure to include: - the resident must be provided written information on medications, including any specific instructions for administering or handling the medications, including controlled substances; - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; and - how the RN shall be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative. On January 24, 2022, at approximately 9:00 a.m., RN-A confirmed the licensee's policy did not include the above noted written procedure as required. ULP-C started employment on September 13, 2019, under the comprehensive home care license and began providing assisted living	{01790}		

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{01790}	Continued From page 45 services on August 1, 2021. R3's January 2022 medication administration record (MAR) indicated ULP-C administered medications to R3. ULP-D started employment on July 17, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On January 24, 2022, at approximately 11:00 a.m., registered nurse (RN)-A stated ULP-D provided direct care services to residents. On January 24, 2022, at approximately 9:00 a.m., RN-A confirmed ULP-C, ULP-D, and all other ULP at the facility, had not been trained or demonstrated competency to provide medications for residents having unplanned times away. The licensee's policy, Medications For A Client Who Will Be Away From Home When Medications Are Scheduled, dated January 1, 2021, noted for unplanned times away from home the RN may delegate the task to ULP if the RN had trained the ULP and determined the ULP to be competent to follow the procedures for providing medications to residents. In addition, when medications were provided to the resident or the resident's designated representative for unplanned time away, the process must be documented in the resident record to include the name of the person that received the medications, the time and date the medications were provided to the resident, which medications were provided and the amount of medications provided, and the name and title of the ULP who provided the medications to the resident or the	{01790}		

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{01790}	Continued From page 46 resident's designated representative. Also, medications sent with a resident during an absence and were not used would be appropriately documented by the receiving staff including the medication name, quantity, and reason returned. No further information was provided.	{01790}		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The	{01940}		

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{01940}	Continued From page 47 treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment management plan to include all required content for one of one resident (R2) receiving treatment management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on January 24, 2022, at approximately 9:00 a.m., registered nurse (RN)-A confirmed the licensee provided treatment and therapy services to residents. R2's records lacked evidence a treatment management plan had been developed and implemented. R2's service plan dated July 22, 2021 indicated R2 received treatment management services. R2's prescriber's orders dated July 22, 2021, included to wear a continuous positive airway pressure (CPAP) machine at bedtime and R2 required assistance with cleaning the CPAP machine.	{01940}		

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{01940}	Continued From page 48 On January 24, 2022, at approximately 10:30 a.m., RN-A confirmed unlicensed personnel (ULP) cleaned R2's CPAP machine daily. RN-A provided specific written instructions for how to clean R2's CPAP machine. R2's record lacked documentation to indicate the CPAP machine was cleaned as ordered. R2's record lacked evidence the RN developed a treatment management plan to include the required content for cleaning of the CPAP machine: - a statement of the type of services that would be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On January 24, 2022, at approximately 12:10 p.m., RN-A confirmed she had not developed a treatment management plan for R2 as indicated above. RN-A stated she was working on updating all policies and procedures. The licensee's Treatment Management policy dated January 2019 did not include the development of a treatment management plan.	{01940}		

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{01940}	Continued From page 49 No further information was provided.	{01940}		
{01950} SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prior to delegating nursing tasks, the registered nurse (RN) trained the unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident, and failed to ensure the ULP demonstrated the ability to competently follow the procedure to perform the tasks for two of two employees (ULP-C and ULP-D) with records	{01950}		

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{01950}	Continued From page 50	{01950}		

reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).
The findings include:
ULP-C started employment on September 13, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

ULP-D started employment on July 17, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

R2's prescriber orders dated July 22, 2021, included to wear continuous positive airway pressure (CPAP) machine at bedtime and R2 required assistance with cleaning the CPAP machine.

R2's record lacked documentation to indicate the CPAP machine was cleaned as ordered.

ULP-C and ULP-D's employee records lacked evidence the registered nurse (RN) trained the ULP or that the ULP demonstrated competency to the RN pertaining to the cleaning of R2's CPAP machine.

On January 24, 2022, at approximately 1:00 p.m., registered nurse (RN)-A confirmed ULP-C and ULP-D had both cleaned R2's CPAP machine.

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{01950}	Continued From page 51 RN-A confirmed ULP-C and ULP-D's employee records lacked evidence the employees were trained or demonstrated competency to the RN as indicated above. RN-A indicated she provided written instructions for the cleaning of R2's CPAP machine. The licensee's Treatment or Therapy Management Plans policy dated January 1, 2021, indicated treatment and therapies would be delegated to the unlicensed personnel after they have been trained and deemed competent by the RN. No further information was provided.	{01950}		
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatments for one of one resident (R2) with records reviewed. This practice resulted in a level two violation (a	{01960}		

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{01960}	Continued From page 52 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2's prescriber's orders dated July 22, 2021, included for R2 to wear a continuous positive airway pressure (CPAP) machine at bedtime and R2 required assistance with cleaning the CPAP. R2's record lacked documentation to indicate the CPAP machine was cleaned as ordered. On January 24, 2022, at approximately 1:00 p.m., registered nurse (RN)-A stated unlicensed personnel (ULP) clean R2's CPAP machine daily. RN-A stated ULP should document the cleaning of the CPAP machine on R2's medication administration record. RN-A confirmed R2's record lacked documentation of R2's treatment as indicated above. The licensee's policy, Client Record-Outline, dated January 1, 2021, indicated the resident record must include documentation of all services provided. No further information was provided.	{01960}		

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Follow-Up
Date: *01/24/22*
Time: 10:30:00
Report: 8010221020

Food and Beverage Establishment Inspection Report

Location:
Garden House Estates Ltd
1 Riverside Drive
Duluth, MN55808
St. Louis County, 69

Establishment Info:
ID #: 0039293
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2186280271
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 previously issued on 10/06/21 have NOT been corrected.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

PROVIDE TEMPERATURE TAPES TO TEST THE UTENSIL SURFACE TEMPERATURE OF THE DISHWASHER. THE UTENSIL SURFACE TEMPERATURE IS TO REACH 160F.

Issued on: 10/06/21 *Comply By: 10/06/21*

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location: DISHWASHER SANITIZING RINSE-TEMP TAPE TURNED BLACK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 142 Degrees Fahrenheit - Location: SLOPPY JOE-OVEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK-BEVERAGE AIR
Violation Issued: No

Type: Follow-Up
Date: *01/24/22*
Time: 10:30:00
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Garden House Estates Ltd

Food and Beverage Establishment Inspection Report

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-ARTIC AIR
Violation Issued: No

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

COMMENTS:

THIS WAS A FOLLOWUP INSPECTION TO THE INSPECTION DONE ON 10/06/2021.

ONE OF THE TWO ORDERS HAS BEEN CORRECTED.

DISCUSSED THE EXCLUSION OF EMPLOYEES ILL WITH VOMITING OR DIARRHEA FROM THE FOOD ESTABLISHMENT FOR 24 HOURS AFTER SYMPTOMS ARE GONE WITH ANTHONY.

REVIEWED THE USE OF RAW EGGS THAT ARE ONLY TO BE USED IN ONE RESIDENT'S SERVING AT A SINGLE MEAL IF THE EGGS ARE COMBINED, COOKED AND SERVED IMMEDIATELY SUCH AS IN AN OMELET, SOUFFLE, OR SCRAMBLED OR IN BAKED GOODS THAT ARE THOROUGHLY COOKED IF EGGS ARE COMBINED AS AN INGREDIENT IMMEDIATELY BEFORE BAKING.

REVIEWED THAT PASTEURIZED EGGS OR EGG PRODUCTS MUST BE SUBSTITUTED FOR RAW EGGS WHEN MORE THAN ONE EGG IS BROKEN, COMBINED AND NOT COOKED, BAKED, OR USED IMMEDIATELY.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8010221020 of 01/24/22.

Certified Food Protection Manager: Anthony Moen

Certification Number: FM81471 Expires: 01/11/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Anthony Moen
Kitchen Manager

Signed: _____
8010

651-201-4500
health.foodlodging@state.mn.us

Report #: 8010221020

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	**Date**	01/24/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	10:30:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

Garden House Estates Ltd	**Address** 1 Riverside Drive	**City/State** Duluth, MN	**Zip Code** 55808	**Telephone** 2186280271
License/Permit # 0039293	**Permit Holder**	**Purpose of Inspection** Follow-Up	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 01/25/22

Inspector (Signature)

Electronically Delivered

November 15, 2021

Administrator
Garden House Estates Ltd
1 Riverside Drive
Duluth, MN 55808

RE: Project Number(s) SL30814015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 20, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

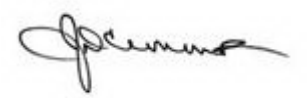
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.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

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

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

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

Sincerely,



Jeri Cummins, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jeri.cummins@state.mn.us
Telephone: 218-302-6193 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30814	A. BUILDING: _____ B. WING _____	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN HOUSE ESTATES LTD	1 RIVERSIDE DRIVE DULUTH, MN 55808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL#30814015 On October 18, 2021 through October 20, 2021, 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 22 residents that were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the	0 250		

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0 250	Continued From page 1 license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the	0 250		

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0 250	Continued From page 2 assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the assisted living services, understood all of the assisted living provider regulations; and the licensee failed to ensure policies and procedures were developed and/or implemented. This had the potential to affect all twenty-two (22) 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 14, 2021, at approximately 10:30 a.m., registered nurse (RN)-A confirmed she was responsible for and participated in the facility's day-to-day operations. RN-A stated she was familiar with some of the Assisted Living licensing rules. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read	0 250		

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0 250	Continued From page 3 and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window). - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data (opens in a new window), the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the	0 250		

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0 250	Continued From page 4 submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, ins some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of	0 250		

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0 250	Continued From page 5 my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable. Page five was electronically signed by the owner on May 30, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee had attested they read and understood the Assisted Living licensing statues. The licensee failed to implement the following required policies and procedures: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a residents condition are identified, managed, and communicated to staff and other health care providers as appropriate; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with	0 250		

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0 250	Continued From page 6 current United States Centers for Disease Control and Prevention standards; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals. Refer to licensing order at Statute 144G.42, Subd. 9. The licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure a TB Risk Assessment had been completed and licensee failed to ensure history and symptoms screening and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for three of thee employees RN-A, unlicensed personnel(ULP)-C and ULP-D) with employee records reviewed. Refer to licensing order at Statute 144G.61 Subd. 2. The licensee failed to ensure training and competency evaluations contained all the required training for two of two employees (ULP-C and ULP-D) with records reviewed. Refer to licensing order at Statute 144G.61 Subd. 2. The licensee failed to ensure training and competency evaluations contained all the required training for two of two employees (ULP-C and ULP-D) with records reviewed. Refer to licensing order at Statute 144G.63, Subd. 2. The licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations for three of three employees (RN-A, ULP-C, and ULP-D) with records reviewed.	0 250		

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0 250	Continued From page 7 Refer to licensing order at Statute 144G.70, Subd. 2. The licensee failed to ensure the RN completed a comprehensive reassessment using the uniform assessment tool on day 90 for three of three residents (R1, R2, and R3) as required with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 5. The licensee failed to ensure a individualized medication management plan was completed for three of three residents (R1, R2, and R3) with records reviewed. Refer to licensing order at Statute 144G.71. Subd. 7. The licensee failed to ensure prior to delegating nursing tasks, the ULP were trained in the proper methods to perform the task or procedure for each resident, and were able to demonstrate the ability to competently follow the procedure to perform the tasks for one of two employees (ULP-C). In addition, the RN failed to specify, in writing, specific instructions for one of three residents (R1) for administration of medications. Refer to licensing order at Statute 144G.71, Subd.8. The licensee failed to ensure the effectiveness of PRN (as necessary) medications was documented for one of one resident (R3) and failed to ensure medications were documented after administration. Refer to licensing order at Statute 144G.71, Subd. 10. the licensee failed to ensure the RN developed written procedures for unplanned time away from home, and the licensee failed to ensure two of two employees (ULP-C and ULP-D) were trained and had demonstrated competency to prepare and give medications for	0 250		

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0 250	Continued From page 8 residents having unplanned time away. Refer to licensing order at Statute 144G.71, Subd. 22. The licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R4) with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 23. the licensee failed to ensure the licensee's loss and spillage policy was complete. Refer to licensing order at Statute 144G.72, Subd. 3. The licensee failed to develop a treatment management plan to include all required content for two of two residents (R1 and R2) receiving treatment management services. Refer to licensing order at Statute 144G.72, Subd. 4. The licensee failed to ensure prior to delegating nursing tasks, the ULP were trained in the proper methods to perform the task or procedure for each resident, and were able to demonstrate the ability to competently follow the procedure to perform the tasks for two of two employees (ULP-C and ULP-D) with records reviewed. In addition, the licensee failed to ensure the RN specified, in writing, specific instructions for treatments two of two residents (R1 and R2) were receiving. Refer to licensing order at Statute 144G.72, Subd. 5. The licensee failed to document treatments for two of two residents (R1 and R2) with records reviewed.	0 250		

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0 250	Continued From page 9 On October 20, 2021, at approximately 9:00 a.m., RN-A confirmed the above listed policies and procedures had not been successfully implemented. Thirty-five (35) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited or not evident for compliance with sections 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).	0 430		

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0 430	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the uniform checklist of disclosure was provided to three of three residents (R1, R2, and R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R2, and R3's records lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of all services offered under the contract. On October 19, 2021, at approximately 6:13 a.m., unlicensed personnel (ULP)-C was observed to administer oral medications to R1. R1's Service Plan dated May 5, 2020, indicated services included medication administration, assistance with bathing grooming, dressing, laundry, and housekeeping.	0 430		

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0 430	Continued From page 11 On October 19, 2021, at approximately 7:30 a.m., ULP-D was observed to administer oral medications to R2 and assisting R2 with dressing. R2's Service Plan dated July 22, 2021, indicated services included medication administration, assistance with shower, dressing as needed, and cleaning of a CPAP (continuous positive airway pressure) machine daily. On October 19, 2021, at approximately 6:00 a.m., ULP-C was observed to administer oral medications to R3. R3's Service Plan dated December 19, 2017, indicated services included medication administration and assistance with bathing, grooming, incontinent care, laundry and housekeeping. On October 20, 2021, at approximately 9:00 a.m., registered nurse (RN)-A confirmed R1, R2, R3, and all residents receiving services under the licensee's Assisted Living License had not received the uniform checklist disclosure of services. In addition, RN-A stated she was not aware of what the uniform checklist disclosure of services was. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		

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0 450	Continued From page 12	0 450		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the assisted living bill of rights to three of three residents (R1, R2 and R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R2, and R3's records lacked evidence the residents received Assisted Living Bill of Rights dated May 16, 2021. On October 19, 2021, at approximately 6:13 a.m., unlicensed personnel (ULP)-C was observed to administer oral medications to R1. R1's record indicated R1 received a copy of the	0 450		

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0 450	Continued From page 13 Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers dated November 2019, on May 5, 2020. On October 19, 2021, at approximately 7:30 a.m., ULP-D was observed to administer oral medications to R2 and assisting R2 with dressing. R2's record indicated R2 received a copy of the Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers dated November 2019, on July 22, 2021. On October 19, 2021, at approximately 6:00 a.m., ULP-C was observed to administer oral medications to R3. R3's record indicated R3 received a copy of the Minnesota Home Care Bill of Rights for Assisted Living Clients on February 11, 2013. On October 18, 2021, at approximately 11:45 a.m., during the tour, registered nurse (RN)-A pointed out to the surveyor that she had posted the Assisted Living Bill of Rights dated May 16, 2021, on the bulletin board by the main entrance. On October, 20, 2021, at approximately 9:00 a.m., RN-A confirmed R1, R2, R3, and all residents receiving services under the licensee's Assisted Living license had not received the Assisted Living Bill of Rights dated May 16, 2021. The licensee's 1.03 Bill of Rights policy dated January 1, 2019, indicated all "Home Care Clients" shall receive the Minnesota Home Care Bill of Rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 14 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the staffing plan was developed and posted as required, potentially affecting all twenty-two (22) residents in the assisted living facility, staff and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 470		

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0 470	Continued From page 15 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 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. On October 18, 2021, at approximately 10:30 a.m., registered nurse (RN)-A confirmed a staffing plan had not been developed to address the content listed above. In addition, RN-A confirmed a staffing plan was not posted on each unit. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		

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0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced 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 had the potential to affect all twenty-two (22) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 480		

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0 480	Continued From page 17 Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated October 5, 2021 , for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a menu was prepared at least a week in advance and provided to the residents. This had the potential	0 485		

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0 485	Continued From page 18 to affect all twenty-two (22) residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 18, 2021, at approximately 11:45 a.m., kitchen manager (KM)-F provided the surveyor with a copy of a weekly menu plan for the week of October 18, 2021. The weekly menu plan only included menus for the lunch and dinner meals on October 18, 19, 20, 21, and 22, 2021. There were no planned menus for the breakfast meal or the lunch and dinner meal on October 23 and 24, 2021. KM-F stated he did not prepare the menu a week in advance, and the weekly menu is not provided to the residents. The residents are told daily what is on the menu. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place	0 550		

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0 550	Continued From page 19 information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post in a conspicuous place, information about the facility's grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This had the potential to affect all twenty-two (22) 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, 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).	0 550		

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0 550	Continued From page 20 The findings include: On October 18, 2021, at approximately 11:45 a.m., during a facility tour, the licensee did not have posted the required grievance procedure content in a conspicuous place. On October 18, 2021, at 11:45 p.m., registered nurse (RN)-A confirmed the required grievance procedure content had not been posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all of the licensee's current residents, staff and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 570		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN HOUSE ESTATES LTD	1 RIVERSIDE DRIVE DULUTH, MN 55808

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0 570	Continued From page 21 the residents). The findings include: On October 18, 2021, at approximately 10:15 a.m., upon entering the facility, the license was not observed to be posted at the facility entrance as required. On October 18, 2021, at approximately 11:45 a.m., registered nurse (RN)-A confirmed the original current license was not posted at the main entrance. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
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.	0 580		

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0 580	Continued From page 22 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity. This had the potential to affect all twenty-two (22) 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 18, 2021, at approximately 10:30 a.m., during the entrance conference, the registered nurse (RN)-A stated she was unaware of the requirement pertaining to quality management activities. On October 20, 2021, at approximately 9:00 a.m., RN-A confirmed there was no current documentation of quality management activity. The licensee's Quality Improvement Project policy, dated January 1, 2019, indicated the licensee would have at least one documented quality improvement project in place at all times and retain records of such projects for at least two years. No further information was provided.	0 580		

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0 580	Continued From page 23 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 support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all twenty-two (22) residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 640		

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0 640	Continued From page 24 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 18, 2021, at approximately 11:45 a.m., during a facility tour, the licensee did not have the 911 emergency number and the required MAARC information posted in common areas and near telephones. On October 18, 2021, at 11:45 a.m., registered nurse (RN)-A confirmed the 911 emergency number and the required MAARC information was not posted in common areas and near telephones. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=B	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training	0 650		

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0 650	Continued From page 25 and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for two of three employees, registered nurse (RN)-A and unlicensed personnel (ULP)-D with employee records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive).	0 650		

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0 650	Continued From page 26 The findings include: RN-A's employee record showed RN-A had a start date of August 1, 2021. RN-A's employee record did not contain a job description, including qualification, responsibilities, and identification of staff persons providing supervision. ULP-D's employee record had a start date of August 1, 2021. ULP-D's employee record did not contain a job description, including qualifications, responsibilities, and identification of staff persons providing supervision. On October 20, 2021, at approximately 9:00 a.m., RN-A confirmed RN-A and ULP-D's employee records lacked a job description. The licensee's Personnel Files/Employee Records policy dated January 1, 2021, indicated employee files shall contain a current job description. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity	0 660		

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0 660	Continued From page 27 and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to complete a TB Risk Assessment and ensure a history and symptoms screening and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for three of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-C, and ULP-D) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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: During the entrance conference on October 18, 2021, at approximately 10:30 a.m., with registered nurse (RN)-A, a request was made to	0 660		

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0 660	Continued From page 28 review the facility TB risk assessment. RN-A stated a facility TB risk assessment had not been completed for this location. RN-A, ULP-C and ULP-D's employee records lacked evidence of a completed health history and symptom screening, including completion of a two-step TST or other evidence of TB screening, such as a blood test. RN-A, ULP-C and ULP-D each had a hire date of August 1, 2021. Throughout the survey, RN-A was observed providing direct care to residents and supervision to ULPs. RN-A's employee record indicated she had a one step TST on August 10, 2021. RN-A's employee record lacked evidence a TB history and symptom screen had been completed. On October 19, 2021, at approximately 6:13 a.m., ULP-C was observed to administer R1's morning medications. ULP-C's employee record lacked evidence a TB history and symptom screen and a two-step TST had been completed. On October 19, 2021, at approximately 7:30 a.m., ULP-D was observed to administer R2's morning medications. ULP-D's employee record lacked evidence a TB history and symptom screen had been completed. On October 20, 2021, at approximately 9:00 a.m., RN-A confirmed RN-A, ULP-C and ULP-D's records lacked evidence they had received the required TB history and symptom screen and	0 660		

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0 660	Continued From page 29 two-step TST as indicated above. The licensee's Tuberculosis and Staff Screening policy dated January 1, 2021, indicated the licensee shall complete a written community TB Risk Assessment. Employees shall be screened and test for TB prior before staff being exposed to "clients." The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. 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 (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	0 680		

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0 680	Continued From page 30 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency disaster plan with all required content and failed to post an emergency plan prominently. 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).	0 680		

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0 680	Continued From page 31 The findings include: During the entrance conference on October 18, 2021, at approximately 10:30 a.m., an Minnesota Department of Health (MDH) surveyor requested to view the licensee's emergency preparedness plan. Registered nurse (RN)-A was not sure the licensee had an emergency preparedness plan. On October 18, 2021, at approximately 1:30 p.m., an MDH surveyor toured the facility with RN-A. There was no observed signage or information posted regarding the licensee's emergency plan in the assisted living building. On October 20, 2021, at approximately 9:00 a.m., RN-A confirmed the licensee did not have an emergency preparedness plan that included the following required content: -a risk assessment for the facility; - a comprehensive program to include 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; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility) - shelter in place; - a tracking system used to document locations or residents and staff - the medical record documentation system to preserve resident information - emergency staff strategies	0 680		

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0 680	Continued From page 32 - the facility's role in providing care and treatment at alternative sites - a communication plan that included: - arrangement with other facilities - names and contact information for staff, resident physicians, other facilities - contact information for federal, state, tribal, local EP staff, ombudsman - 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 -a method of sharing information from the emergency plan with residents and their families - EP training and testing program - EP training program for staff (including documentation of training provided) - EP testing/annual testing requirements. A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 690 SS=B	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the	0 690		

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0 690	Continued From page 33 person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in the resident's records were authenticated by the name and title of the person making the entry for three of three residents (R1, R2, and R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: R1's incident reports were not authenticated by the name and title of the person making the entry as follows: Incident report dated September 6, 2021, the person making the report did not include their title. Incident report dated September 17, 2021, the registered nurse (RN) authenticated the report by using her first name, last name initial, and title. Incident report dated September 21, 2021, the person making the report did not include their title. The RN authenticated the report by using her first name, last name initial and title. Incident report dated September 30, 2021, the person making the report did not include their title. Several of R1's Progress Notes dated September 6, 2021, to October 15, 2021, were authenticated only with the RN's first name, last name initial,	0 690		

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0 690	Continued From page 34 and title. R2's Progress Notes dated August 9, 2021, and September 22, 2021, were authenticated only with the RN's first name, last name initial, and title. R3's 90-day assessment dated June 28, 2021, was authenticated only with the RN's first name, last name initial, and title. On October 20, 2021, at approximately 9:00 a.m., RN-A confirmed the above entries were not authenticated with the name and title of the person making the entry. The licensee's Client Record-Documentation policy dated January 1, 2019, indicated all documentation must include the signature and title of the person who performed the service. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any;	0 730		

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GARDEN HOUSE ESTATES LTD	1 RIVERSIDE DRIVE DULUTH, MN 55808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 730	Continued From page 35 (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record contained documentation of the services being provided for three of three residents (R1, R2, and R3) and failed to ensure the resident record contained documentation of complaints received and any resolution for one of one resident (R3) with records reviewed.	0 730		

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0 730	Continued From page 36 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1, R2, and R3's records lacked documentation of the services being provided by the licensee. On October 19, 2021, at approximately 6:13 a.m., unlicensed personnel (ULP)-C was observed to administer oral medications to R1. R1's Service Plan dated May 5, 2020, indicated services included medication administration; bathing assistance two times a week; grooming, set-up and reminders; dressing, assistance with pants; laundry one time a week; and housekeeping one time a week. R1's Resident Service Record for October 2021 indicated the ULP only documented the services provided to the resident one out of 16 days in October 2021. On October 19, 2021, at approximately 7:30 a.m., ULP-D was observed to administer oral medications to R2 and assist R2 with dressing. R2's Service Plan dated July 22, 2021, indicated services included medication administration, assistance with showers, dressing as needed, personal laundry one time a week and PRN (as necessary), and housekeeping/linen change one time a week. R2's Resident Service Record for October 2021 indicated the ULP only documented weekly laundry was provided. On October 19, 2021, at approximately 6:00 a.m.,	0 730		

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0 730	Continued From page 37 ULP-C was observed to administer oral medications to R3. R3's Service Plan dated December 19, 2017, indicated services included medication administration; assistance with bathing two times a week; grooming assistance two times a day; laundry provided weekly; and housekeeping provided weekly. R3's Resident Service Record for October 2021 indicated the ULP only documented the services provided one out of 16 days in October 2021. On October 20, 2021, at approximately 9:00 a.m., RN-A confirmed R1, R2, and R3's records lacked documentation of the services provided as written on the residents' service plans. On October 19, 2021, at approximately 9:00 a.m., R3 stated she had reported missing money to the licensee's staff. R3 stated the staff looked for the money in her room and they never found it, but that nothing more was done. R3 did not go into any other detail. R3's Progress Notes indicated the following: -On August 27, 2021, "resident came down to the office very upset round 3 p.m., saying she is missing around $100.00 from her wallet." "Staff looked in her wallet and found $4 in one dollar bills in her wallet." R3 said it happened between Sunday August 22, 2021, and Friday August 27, 2021 and, "She stated her husband put around $100 in her wallet." Staff noted they notified the administrator. -On September 1, 2021, at 11:00 a.m., staff noted they went to R3's room with the administrator (A)-B at R3's request. Staff noted R3 talked about calling the State regarding the alleged missing money and that A-B stressed that R3 refused to allow staff to assist her to look for the money. A-B	0 730		

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0 730	Continued From page 38 also stressed that R3 could have spoken to her about the situation first and that reporting the facility to the State about this situation is inappropriate because the State is for abuse and neglect;a police report should have been filed instead. The resident agreed at the end to allow staff to look in her room for the money. R3's record lacked documentation of any investigation other than looking for the money or any resolution of the complaint. On October 20, 2021, at approximately 9:00 a.m., registered nurse (RN)-A stated she talked to A-B about R3's complaint of missing money and if any further investigation was completed and documented. RN-A stated there was no further investigation and documentation pertaining to the complaint. The licensee's Client Record-Outline policy dated January 1, 2021, indicated the resident's record must include: -documentation that services have been provided as identified in the service plan; and -documentation of complaints received and resolution. No further documentation was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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:	0 780		

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0 780	Continued From page 39 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide smoke alarms that complied with fire protection requirements. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 780		

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0 780	Continued From page 40 On October 20, 2021, between 10:15 a.m. and 11:30 a.m., survey staff toured the facility with maintenance personnel (M)-E. During the tour, the following observation was made: Two smoke detectors were installed in resident room 203. M-E confirmed during the tour interview that they did not know if these smoke detectors would activiate an alarm within this dwelling unit. During the exit interview, on October 20, 2021, at approximately 12:40 p.m., registered nurse (RN)-A stated that they did not know if the smoke detectors installed in resident room 203 would activiate an alarm within this dwelling unit. RN-A stated that the building owner was on vacation, and the owner would be able to provide this information. Survey staff requested information be provided no later than October 29, 2021, on how smoke detectors would function in room 203 upon activation. No further information or documentation was provided as of November 4, 2021 at 11:30 a.m. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided	0 900		

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0 900	Continued From page 41 directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute an assisted living contract to include all required content for three of three residents (R1, R2, and R3) 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, but was not likely to	0 900		

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0 900	Continued From page 42	0 900		

cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R1, R2, and R3's records lacked a written contract with the following required content:
(a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.
(b) The contract must contain all the terms concerning the provision of:
(1) housing;
(2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and
(3) the resident's service plan, if applicable.
(c) A facility must:
(1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and
(2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments to the resident promptly after a contract and any addendum has been signed.
(d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.
(e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.
(f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing

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0 900	Continued From page 43 contract must be executed and signed. On October 19, 2021, at approximately 6:13 a.m., unlicensed personnel (ULP)-C was observed to administer oral medications to R1. R1's Service Plan dated May 5, 2020, indicated services included medication administration and assistance with bathing grooming, dressing, laundry, and housekeeping. On October 19, 2021, at approximately 7:30 a.m., ULP-D was observed to administer oral medications to R2 and assist R2 with dressing. R2's Service Plan dated July 22, 2021, indicated services included medication administration, assistance with shower, dressing as needed, and cleaning of a CPAP (continuous positive airway pressure) machine daily. On October 19, 2021, at approximately 6:00 a.m., ULP-C was observed to administer oral medications to R3. R3's Service Plan dated December 19, 2017, indicated services included medication administration assistance with bathing, grooming, incontinent care, laundry and housekeeping. On October 20, 2021, at approximately 9:00 a.m., registered nurse (RN)-A confirmed an assisted living contract had not been developed or implemented for R1, R2, R3, and all other residents receiving services under the licensee's Assisted Living License. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021.	0 900		

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0 900	Continued From page 44 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01370 SS=E	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences,	01370		

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01370	Continued From page 45 cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations contained all the required training for two of two employees (unlicensed personnel (ULP)-C and ULP-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C and ULP-D's employee records lacked evidence the ULPs demonstrated competency in all the required topics. ULP-C was hired on August 1, 2021, to provide direct care under the licensee's Assisted Living License. On October 19, 2021, at approximately 6:13 a.m., ULP-C was observed to administer oral	01370		

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01370	Continued From page 46 medications to R1. ULP-C's employee record lacked evidence she had demonstrated competency in the following areas: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting. ULP-D was hired on August 1, 2021, to provide direct care under the licensee's Assisted Living License. On October 19, 2021, at approximately 7:30 a.m., ULP-D was observed to administer oral medications to R2 and assist R2 with dressing. ULP-D's employee record lacked evidence she had demonstrated competency in the following areas: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting. On October 20, 2021, at approximately, 9:00 a.m., registered nurse (RN)-A confirmed ULP-C and ULP-D's employee records lacked evidence they had received training and competency evaluations in the areas identified above. The licensee's Training and Competency Training policy dated January 1, 2021, indicated ULPs would be trained and demonstrate competency in the following areas:	01370		

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01370	Continued From page 47 - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=E	144G.61 Subd. 2 Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure training and competency evaluations contained all the required training for two of two employees	01380		

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01380	Continued From page 48 (unlicensed personnel (ULP)-C and ULP-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C and ULP-D's employee records lacked evidence the ULPs demonstrated competency in all the required topics. ULP-C was hired on August 1, 2021, to provide direct care under the licensee's Assisted Living License. On October 19, 2021, at approximately 6:13 a.m., ULP-C was observed to administer oral medications to R1. ULP-C's employee record lacked evidence she had demonstrated competency in the following areas: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motion and positioning. ULP-D was hired on August 1, 2021, to provide direct care under the licensee's Assisted Living License. On October 19, 2021, at approximately 7:30 a.m., ULP-D was observed to administer oral medications to R2 and assist R2 with dressing. ULP-D's employee record lacked evidence she had demonstrated competency in the following areas: -reading and recording temperature, pulse, and	01380		

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01380	Continued From page 49 respirations of the resident; -safe transfer techniques and ambulation; and -range of motion and positioning. On October 20, 2021, at approximately 9:00 a.m., registered nurse (RN)-A confirmed ULP-C and ULP-D employee records lacked evidence they had received competency training in the areas identified above. The licensee's Training and Competency Training policy dated January 1, 2021, indicated ULPs would be trained and demonstrate competency in the following areas: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motion and position. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting	01470		

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01470	Continued From page 50 Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies,	01470		

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01470	Continued From page 51 assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations for three of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-C, and ULP-D) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: RN-A, ULP-C, and ULP-D's records lacked evidence to indicate the employees received orientation to include the following topics: - an overview of this chapter; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. RN-A, ULP-C, and ULP-D began providing assisted living services for the licensee on August 1, 2021. The employees' records lacked the above required content.	01470		

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01470	Continued From page 52 Throughout the survey RN-A was observed to provide direct care to residents and supervise ULPs. On October 19, 2021, at approximately 6:13 a.m., ULP-C was observed to administer oral medications to R1. On October 19, 2021, at approximately 7:30 a.m., ULP-D was observed to administer oral medications to R2 and assist R2 with dressing. On October 20, 2021, at approximately 9:00 a.m., RN-C confirmed RN-A, ULP-C, ULP-D, and all other employees had not received training as indicated above. An orientation training policy was requested, but was not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed	01530		

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01530	Continued From page 53 at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three employees unlicensed personnel (ULP)-C, ULP-D and registered nurse (RN)-A) received the required amount of dementia care training in the required time frame with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: RN-A was hired on August 1, 2021, to provide and supervise direct care services to the licensee's residents.	01530		

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01530	Continued From page 54 RN-A's record indicated RN-A had received the following training: -interview and overview; -communication; -activities of daily living; -behaviors various symptoms; and -the journey. ULP-C was hired on August 1, 2021, to provide direct care services to the licensee's residents. ULP-C's record indicated ULP-C completed a "dementia refresher" on January 24, 2019. ULP-C's employee record did not indicate ULP-C completed a total of eight hours of the required dementia training. ULP-D was hired on August 1, 2021, to provided services to the licensee's residents. ULP-D's record indicated ULP-D had received the following training: -interview and overview; -communication; -activities of daily living; -behaviors various symptoms; and -the journey. RN-A, ULP-C, and ULP-D's employee records did not indicate a total of eight hours of the required dementia training was completed. On October 20, 2021, at approximately 9:00 a.m., RN-A stated she was aware of the for eight hours of dementia training requirement and was in the process of scheduling the training. RN-A confirmed the above employees had not received the required eight hours of dementia training.	01530		

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01530	Continued From page 55 The licensee's Alzheimer's Disease and Related Disorder Training and Notification policy dated January 1, 2019, indicated the licensee would provide the required training. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01530		
01620 SS=E	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 56 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool on day 90 for three of three residents (R1, R2, and R3) as required with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1's 90-day reassessment did not include all the required elements on the uniform assessment tool. On October 19, 2021, at approximately 6:13 a.m., unlicensed personnel (ULP)-C was observed to administer oral medications to R1. R1's Service Plan dated May 5, 2020, indicated services included medication administration, assistance with bathing assistance two times a week; grooming, set-up and reminders; dressing, assistance with pants; laundry one time a week; and housekeeping one time a week. R1's record included a Monitoring and Reassessment for a 90-day visit dated August 31,	01620		

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01620	Continued From page 57	01620		

2021. This assessment indicated R1 required assistance with bathing, dressing, housekeeping, laundry, and medication administration. This assessment did not include all the elements on the uniform assessment tool as required.

R2's 14 day and 90 day reassessments did not include all the required elements on the uniform assessment tool.

On October 19, 2021, at approximately 7:30 a.m., ULP-D was observed to administer oral medications to R2 and assist R2 with dressing.

R2's Service Plan dated July 22, 2021, indicated services included medication administration, assistance with shower, dressing as needed, personal laundry one time a week and PRN (as necessary), and housekeeping/linen change one time a week.

R2's record included a Monitoring and Reassessment for a 14-day visit dated August 5, 2021, and a Monitoring and Reassessment for a 90-day visit dated October 4, 2021. These assessments did not include all the elements on the uniform assessment tool as required.

R3's record lacked evidence a reassessment was completed every 90-days.

On October 19, 2021, at approximately 6:00 a.m., ULP-C was observed to administer oral medications to R3.

R3's Service Plan dated December 19, 2017, indicated services included medication administration assistance with bathing two times a week; grooming assistance two times a day; laundry provided weekly; and house keeping

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01620	Continued From page 58 provided weekly. R3's record included a Monitoring and Reassessment for a 90-day visit dated March 8, 2021, and June 28, 2021. R3's record lacked a 90-day assessment which was due on September 28, 2021. On October 20, 2021, at approximately 9:00 a.m., RN-A confirmed R1 and R2's assessment did not include all the elements on the uniform assessment tool as required. RN-A stated she was not aware of the requirement pertaining to the uniform assessment tool. In addition, RN-A confirmed R3's record lacked evidence a 90-day reassessment had been completed as stated above. The licensee's Assessment Schedule policy dated January 1, 2021, indicated ongoing resident monitoring and reassessment must be done at least every 90 days. The policy did not address the use of a uniform assessment tool. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=B	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services;	01650		

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01650	Continued From page 59 (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure service plans included all the required content for three of three residents (R1, R2, and R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include:	01650		

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01650	Continued From page 60 R1, R2, and R3's service plans lacked the fees for services. On October 19, 2021, at approximately 6:13 a.m., unlicensed personnel (ULP)-C was observed to administer oral medications to R1. R1's Service Plan dated May 5, 2020, lacked the fees for service. On October 19, 2021, at approximately 7:30 a.m., ULP-D was observed to administer oral medications to R2 and assist R2 with dressing. R2's Service Plan dated July 22, 2021, lacked the fees for service. On October 19, 2021, at approximately 6:00 a.m., ULP-C was observed to administer oral medications to R3. R3's Service Plan dated December 19, 2017, lacked the fees for service. On October 20, 2021, at approximately 9:00 a.m., registered nurse (RN)-A confirmed R1, R2, and R3's service plan was incomplete and did not include the above noted content. The licensee's Service Plans policy January 1, 2021, noted the service plan would include, but was not limited to, the fees for services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

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01730	Continued From page 61	01730		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any	01730		

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01730	Continued From page 62 changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete an individualized medication management plan for three of three residents (R1, R2, and R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1, R2, and R3's records lacked evidence the licensee developed and implemented an individualized medication management plan for the residents. During the entrance conference on October 18, 2021, at approximately 10:30 a.m., registered nurse (RN)-A confirmed the licensee provided medication management services to all their residents. R1's service plan dated May 5, 2020, indicated R1 received assistance with medication administration. R1's prescriber's orders dated October 7, 2021, included the following medications: two pain relievers, one medication to treat heartburn, two	01730		

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medications to treat diabetes, one broncho dilator; one medication to prevent recurring urinary tract infection, and one medication to treat allergies.
On October 19, 2021, at approximately 6:13 a.m., unlicensed personnel (ULP)-C was observed to administer R1's morning medications.
R2's service plan dated July 22, 2021, indicated R2 received assistance with medication administration.
R2's prescriber's orders dated July 22, 2021, included the following medications: a medication to treat high blood pressure and a medication to prevent recurring heart attacks.
On October 19, 2021, at approximately 7:30 a.m., ULP-D was observed to administer R2's morning medications.
R3's service plan dated December 19, 2021, indicated R3 received assistance with medication administration.
R3's prescriber's orders dated June 16, 2021, included the following medications; two medications to treat depression, two medications to treat anxiety, one medication to treat water retention, and one medication to lower cholesterol.
On October 19, 2021, at approximately 6:00 a.m., ULP-C stated she had administered R3's morning medications earlier in the morning.
R1, R2, and R3's records lacked evidence a individualized medication management plan had been developed to include the following:
-a statement describing the medication management services that will be provided;
- a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;
- documentation of specific resident instructions relating to the administration of medications;

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01730	Continued From page 64 - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On October 20, 2021, at approximately 9:00 a.m., RN-A confirmed R1, R2, and R3's records lacked evidence an individualized medication management plan had been developed for the resident that included the required content. The licensee's Medication Management Policy (undated) did not include the development of a medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions	01750		

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01750	Continued From page 65 in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident, and were able to demonstrate the ability to competently follow the procedure to perform the tasks for one of two employees (ULP-C). In addition, the registered nurse (RN) failed to specify, in writing, specific instructions for one of three residents (R1) for administration of medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on August 1, 2021, to provide direct care services to residents. On October 19, 2021, at approximately 6:13 a.m., ULP-C was observed to administer oral medications, insulin pens injections, and a medication pain patch to R1. ULP-C's employee record lacked evidence she had been trained and demonstrated competency for the administration of oral medications, insulin	01750		

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01750	Continued From page 66 pens, and medicated patched. R1's record lacked evidence the RN specified, in writing, specific instructions for oral medications, insulin pens, and the application of medication patches. R1's service plan dated May 5, 2020, indicated R1 received services which included medication administration. R1's prescriber's orders dated October 7, 2021, included; loratadine 10 mg (milligrams) daily; Methenam Hip one gram twice daily with meals; omeprazole 20 mg every morning before breakfast; Novolog insulin 12 units if blood glucose is 150 or above at meals; Levemir insulin 45 units every twelve hours; and Salon pas/Lid 4% apply topically to lower back each morning remove after twelve hours. Take off at bedtime. On October 20, 2021, at approximately 9:00 a.m., RN-A confirmed ULP-C's record lacked documentation of the training as indicated above and R1's record lacked instructions specific to administering R1's medications. The licensee's Delegated Nursing Services policy, dated January 1, 2019, indicated the RN may delegate nursing dervices to the ULP after the ULP is trained and competent. Written instructions for performing the procedure for the client in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

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01760	Continued From page 67	01760		
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 the effectiveness of PRN (as necessary) medications was documented in one of one resident (R3), and failed to ensure medications were documented after administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's record lacked documentation of effectiveness of PRN medications. R3's prescriber's orders dated August 30, 2021,	01760		

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01760	Continued From page 68	01760		

included antacid, chew one tablet as needed for dyspepsia; melatonin 5 mg (milligrams) at bed time as need for sleep; Nystatin cream, three times a day for rash PRN; and Robafen 200/10 ml (milliliters) every four hours as needed for cough.
R3's service plan dated December 19, 2017, indicated services included medication administration.
R3's medication administration record (MAR) for September 2021 indicated the following:
-Antacid Chew: 17 out of 17 times administered no effectiveness was documented;
-Melatonin 5 mg: 31 of 31 times administered no effectiveness was documented;
-Nystatin cream: 53 of 53 times administered no effectiveness was documented; and
-Robafen 200/10 ml: 28 of 28 times administered no effectiveness was documented.

On October 20, 2021, at approximately 9:00 a.m., registered nurse (RN)-A confirmed the effectiveness of the above medications was not documented in R3's record.

The licensee's Medication Administration Policy dated January 1, 2019, indicated staff must document a follow-up for PRN medication administration within 60 minutes from the time of administration.

On October 19, 2021, at approximately 7:30 a.m., unlicensed personnel (ULP)-D was observed to set up R2's morning medications into a medication cup, signed R2's MAR by initialing after each medication she placed in the medication cup, and then administered the medication to R2. ULP-D confirmed she documented the administration of R2's medications prior to administering the

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01760	Continued From page 69 medications to R2. On October 20, 2021, at approximately 9:00 a.m., RN-A stated staff are trained to place a dot next to the medication that they set up and come back after administering the medications to document on the residents MAR. The licensee's Medication Administration policy, dated January 1, 2021, indicated staff are to document the administration of medications after they are administered. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:	01790		

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01790	Continued From page 70 (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.	01790		

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01790	Continued From page 71 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for unplanned time away from home and the licensee failed to ensure two of two unlicensed personnel (ULP-C, and ULP-D) were trained and had demonstrated competency to prepare and give medications for clients having unplanned time away. 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: During the entrance conference on October 18, 2021, at approximately 10:30 a.m., registered nurse (RN)-A confirmed the licensee provided medication management services to the majority of residents at the facility, and the ULP would prepare and send medications with the residents for unplanned times away. The licensee failed to develop and implement a written procedure for the ULP providing medications for residents having unplanned times away. The licensee's Medications For A Client Who Will Be Away From Home When Medications Are Scheduled policy dated January 1, 2019,	01790		

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01790	Continued From page 72	01790		

indicated for situations when there would be a short-term absence that was not known in advance and a licensed nurse was not available, the RN may delegate this task to ULP. The RN would develop written procedures for the ULP to follow.

The licensee's policy lacked the written procedure to include:
- the resident must be provided written information on medications, including any specific instructions for administering or handling the medications, including controlled substances;
- the type of container or containers to be used for the medications appropriate to the provider's medication system;
- how the container or containers must be labeled;
- written information about the medications to be provided; and
- how the RN shall be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative.

On October 20, 2021, 2021, at approximately 9:00 a.m., RN-A confirmed the licensee's Medications For A Client Who Will Be Away From Home When Medications Are Scheduled policy did not include the above noted written procedure as required.

ULP-C was hired on August 1, 2021, to provide direct care services under the assisted living with dementia care license to include medication administration.

On October 19, 2021, at 6:13 a.m., ULP-C was observed to administer R1's morning medications and perform blood glucose monitoring.

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01790	Continued From page 73 ULP-C's record lacked evidence to indicate ULP-C had been trained and had demonstrated competency to prepare and provide medications to residents for unplanned times away from home. ULP-D was hired on August 1, 2021, to provide direct care services under the assisted living with dementia care license to include medication administration. On October 19, 2021, at 7:30 a.m., ULP-D was observed to administer R2's morning medications. ULP-D's record lacked evidence to indicate ULP-D had been trained and had demonstrated competency to prepare and provide medications to residents for unplanned times away from home. On October 20, 2021, at approximately 9:00 a.m., RN-A confirmed ULP-C, ULP-D, and all other ULP at the facility, had not been trained or demonstrated competency to provide medications for residents having unplanned times away. The licensee's Medications For A Client Who Will Be Away From Home When Medications Are Scheduled policy dated January 1, 2021, noted for unplanned times away from home the RN may delegate this task ULP if the RN had trained the ULP and determined the ULP to be competent to follow the procedures for providing medications to residents. In addition, when medications were provided to the resident or the resident's designated representative for unplanned time away the process must be documented in the	01790		

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01790	Continued From page 74 resident record to include the name of the person that received the medications, the time and date the medications were provided to the resident, which medications were provided and the amount of medications provided, and the name and title of the ULP who provided the medications to the resident or the resident's designated representative. Also, medications that went with a resident during an absence and were not used would be appropriately documented by the receiving staff including the medication name, quantity, and reason returned. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given,	01910		

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01910	Continued From page 75 date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's record lacked documentation of medication disposition upon discharge. R4's Progress Notes indicated R4 was transferred to the hospital on August 20, 2021, for shortness of breath. R4's service plan dated July 28, 2021, indicated services included medication administration. R4's prescriber orders dated July 28, 2021, included the following medications: one antianxiety medication and one medication to treat diabetes. R4's discharge summary dated August 30, 2021, indicated while R4 was in the hospital it was determined that R4 required a higher level of care and was transferred to a nursing home. R4's family came to collect R4's belongings and	01910		

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01910	Continued From page 76 medications. The licensee's registered nurse (RN) faxed the prescriber's orders and R4's service plan to the nursing home. R4's record lacked evidence of documentation of R4's disposition of medications to include: name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On October 20, 2021, approximately 9:00 a.m., RN-A confirmed the documentation of disposition of R4's medication did not include the required content as indicated above. The licensee's Disposal or Destruction of Medication policy dated January 1, 2019, indicated prescription drugs managed and secured by the facility after death of a resident for whom the drug was prescribed must be destroyed by the RN or LPN with one other person as a witness. Documentation of the destruction, listing the date, quantity, name of drug, prescription number, signature of the person destroying the drugs and signature of witness to the destruction must be recorded in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01920 SS=F	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record	01920		

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01920	Continued From page 77 explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee's loss and spillage policy was complete. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Loss and Spillage Policy of Scheduled II Medications, dated January 1, 2021, was reviewed on October 18, 2021, at approximately 1:30 p.m. Review of the policy revealed the policy did not require the facility providing medication management to investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required record.	01920		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01920	Continued From page 78 On October 18, 2021, at approximately 2:00 p.m., registered nurse (RN)-A confirmed the licensee's Loss and Spillage policy did not include the required content as indicated above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01920		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and	01940		

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01940	Continued From page 79 monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a treatment management plan to include all required content for two of two residents (R1 and R2) receiving treatment management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on October 18, 2021, at approximately 10:30 a.m. registered nurse (RN)-A confirmed the licensee provided treatment and therapy services to residents. R1 and R2's records lacked evidence a treatment management plan had been developed and implemented. R1's service plan dated May 5, 2020, indicated R1 received treatment management services. R1's prescriber orders dated September 30, 2021, included to wear a walking boot on R1's left foot due to fractured toe. Prescriber orders dated	01940		

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01940	Continued From page 80 October 6, 2021, included to continue blood glucose monitoring three times a day. R1's record lacked evidence a treatment management plan had been developed to include the required content for blood glucose monitoring and walking boot: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On October 18, 2020, at approximately 2:00 p.m., R1 was observed sitting a wheelchair with a walking boot on. On October 19, 2021, at approximately 6:13 a.m., unlicensed personnel (ULP)-C was observed to perform R1's blood glucose monitoring. R2's service plan dated July 22, 2021 indicated R2 received treatment management services. R2's prescriber's orders dated July 22, 2021, included to wear continuous positive airway pressure (CPAP) machine at bedtime and required assistance with cleaning.	01940		

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01940	Continued From page 81 On October 19, 2021, at approximately 7:30 a.m., a CPAP machine was observed on a table next to R2's bed. ULP-D stated R2 wears the CPAP machine a night, and the staff clean the machine daily. ULP-D confirmed she had cleaned R2's CPAP machine. R2's record lacked documentation to indicated the resident's CPAP machine was cleaned as ordered. R2's record lacked evidence a treatment management plan had been developed to include the required content for cleaning of the CPAP machine: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On October 20, 2021, at approximately 9:00 a.m., RN-A confirmed treatment management plans had not been developed for R1 and R2 as indicated above. The licensee's Treatment Management policy	01940		

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01940	Continued From page 82 dated January 2019, did not include the development of a treatment management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks, the unlicensed personnel (ULP) were trained in the proper	01950		

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01950	Continued From page 83 methods to perform the task or procedure for each resident, and were able to demonstrate the ability to competently follow the procedure to perform the tasks for two of two employees (unlicensed personnel (ULP)-C and ULP-D) with records reviewed. In addition, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for treatments two of two residents (R1 and R2) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C and ULP-D were hired on August 1, 2021, to provide direct care services to residents. R1's prescriber orders dated September 30, 2021, included to wear a walking boot on R1's left foot due to fractured toe. Prescriber orders dated October 6, 2021, included to continue blood glucose monitoring three times a day. ULP-C's employee record lacked evidence to indicate ULP-C was trained and demonstrated competency to a registered nurse (RN) to perform blood glucose monitoring and application of the walking boot. R1's record lacked evidence the RN had specified, in writing, specific instructions for R1's blood glucose monitoring and walking boot.	01950		

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01950	Continued From page 84 On October 19, 2021, at approximately 6:13 a.m., ULP-C was observed to perform R1's blood glucose monitoring. ULP-C stated she assisted R1 several times throughout the day to apply her walking boot, as R1 often removed the walking boot. R2's prescriber orders dated July 22, 2021, included to wear continuous positive airway pressure (CPAP) machine at bedtime and required assistance with cleaning. R2's record lacked evidence the RN had specified, in writing specific instructions for the cleaning of R2's CPAP machine. On October 19, 2021, at approximately 7:30 a.m., a CPAP machine was observed on a table next to R2's bed. ULP-D stated R2 wears the CPAP machine a night and the staff clean the machine daily. ULP-D confirmed she had cleaned R2's CPAP machine. On October 20, 2021, at approximately 9:00 a.m., RN-A confirmed ULP-C and ULP-D's employee records lacked evidence the employees had been trained and demonstrated competency to the RN as indicated above. RN-A confirmed R1's record lacked written instructions for blood glucose monitoring and walking boot, and R2's record lacked written instructions for cleaning of the resident's CPAP machine. The licensee's Treatment or Therapy Management Plans policy dated January 1, 2021, indicated treatment and therapies will be delegated to the unlicensed personnel after they have been trained and deemed competent by the RN. The RN would specify, in writing, written instructions for treatments and place in the	01950		

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01950	Continued From page 85 resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatments for two of two residents (R1 and R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01960		

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01960	Continued From page 86 The findings include: R1's prescriber orders dated September 30, 2021, included to wear a walking boot on R1's left foot due to fractured toe. R1's record lacked documentation to indicate R1's walking boot was applied as ordered. On October 18, 2021, at approximately 2:00 p.m., R1 was observed sitting in a wheelchair with a walking boot on outside the nurse's office. On October 19, 2021, at approximately 6:13 a.m., ULP-C was observed to perform R1's blood glucose monitoring. ULP-C stated she assisted R1 several times throughout the day to apply her walking boot, as R1 often removed the walking boot. R2's prescriber's orders dated July 22, 2021, included but was not limited to, wear continuous positive airway pressure (CPAP) machine at bedtime and requires assistance with cleaning. R2's record lacked documentation to indicate the resident's CPAP machine cleaned as ordered. On October 19, 2021, at approximately 7:30 a.m., a machine was observed on a table next to R2's bed. ULP-D stated R2 wears the CPAP machine a night, and the staff clean the machine daily. ULP-D confirmed she had cleaned R2's CPAP machine. On October 20, 2021, registered nurse (RN)-A confirmed R1 and R2's records lacked documentation of their treatments as indicated above. The licensee's Client Record-Outline policy dated	01960		

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01960	Continued From page 87 January 1, 2021, indicated the resident record must include documentation of all services provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01960		
02310 SS=D	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R1) who utilized bed rails with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included Alzheimer's dementia. R1's Individual Abuse Prevention Plan dated May 5, 2020, indicated R1 ambulated with the use of a	02310		

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02310	Continued From page 88	02310		

walker, required reminders to use the walker, and had difficulty expressing herself.

On October 19, 2021, at approximately 6:13 a.m., R1 was observed using a bed rail to help herself sit on the edge of the bed, equipped with bilateral side rails, both in the raised position. The rails were approximately three feet wide by one and one-half feet in height. There were four vertical bars four inches apart. The bars were bolted securely to the bed frame.

R1 stated she used the bed rails to help her move in bed and sit up on the edge of bed.

R1's record lacked evidence nursing staff completed a bed rail assessment and explained the risk and benefits of the use of bed rails to R1 or R1's representative.

On October 20, 2021, at approximately 9:00 a.m., registered nurse (RN)-A confirmed a bed rail assessment was not completed for R1.

The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."

A policy regarding assessment and use of side

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02310	Continued From page 89 rails was requested, but none was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable 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 and interview, the licensee	02410		

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failed to ensure privacy was maintained during medication administration for one of four residents (R5) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).
The findings include:
R5's blood glucose monitoring and insulin administration were performed while R5 was seated in an occupied area outside the nurse's office.
On October 19, 2021, at approximately 7:15 a.m., R5 was observed sitting a wheelchair outside the nurse's office talking with another resident. ULP-D administered R5's morning oral medications, applied gloves, performed R5's blood glucose monitoring, changed gloves, and administered Novolog and Victoza injections after lifting up R5's shirt, which exposed R5's abdomen. ULP-D did not ask R5's permission to perform medication administration, blood glucose monitoring or injections outside of the nurse's office in the presence of another resident.
On October 20, 2021, registered nurse (RN)-A stated R5's blood glucose monitoring and insulin injections should be performed in a private area away from other residents.

A policy was requested but not provided.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one

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02410	Continued From page 91 (21) days	02410		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required notice to visitors was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all twenty-two (22) current residents, staff and visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The finding include: On October 18, 2021, at approximately 10:30 a.m., upon arrival to the facility, surveyors	03090		

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03090	Continued From page 92 observed a notice outside the front entrance that indicated, "Security Cameras In Use." On October 18, 2021, at 11:45 a.m., registered nurse (RN)-A confirmed the sign did not contained the required regulatory language. A policy was request but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/06/21*
Time: 10:30:00
Report: 8010211173

Food and Beverage Establishment Inspection Report

Location:
Garden House Estates
1 Riverside Drive
Duluth, MN55808
St. Louis County, 69

Establishment Info:
ID #: N001808
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2186280271
ID #:

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

The following orders were issued during this inspection.

3-800 Highly Susceptible Populations

3-801.11B ** Priority 1 **

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

DISCONTINUE USING UNPASTEURIZED EGGS WHEN MORE THAN ONE EGG IS BROKEN, COMBINED AND NOT COOKED, BAKED, USED OR SERVED IMMEDIATELY AND NOT USED FOR A SINGLE RESIDENT. REFER TO THE HIGHLY SUSCEPTIBLE POPULATION FACT SHEET THAT WAS EMAILED WITH THIS REPORT.

Comply By: 10/06/21

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

PROVIDE TEMPERATURE TAPES TO TEST THE UTENSIL SURFACE TEMPERATURE OF THE DISHWASHER. THE UTENSIL SURFACE TEMPERATURE IS TO REACH 160F.

Comply By: 10/06/21

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location: DISHWASHER SANITIZING RINSE CYCLE-TURNED TEMP TAPE BLACK
Violation Issued: No

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 202 Degrees Fahrenheit - Location: PORK & BEANS
Violation Issued: No

Process/Item: Cooking
Temperature: 167 Degrees Fahrenheit - Location: BRATS
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: SLICED DELI HAM-BEVERAGE AIR
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: COOKED DICED CHICKEN-BEVERAGE AIR
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: SLICED CHEDDAR CHEESE-BEVERAGE AIR
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-BEVERAGE AIR
Violation Issued: No

Process/Item: Chest Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-ARCTIC AIR
Violation Issued: No

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

COMMENTS:

DISCUSSED THE EXCLUSION OF EMPLOYEES ILL WITH VOMITING OR DIARRHEA FROM THE FOOD ESTABLISHMENT FOR 24 HOURS AFTER SYMPTOMS ARE GONE WITH TONY.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8010211173 of 10/06/21.

Certified Food Protection Manager: Anthony Moen

Certification Number: FM81471 Expires: 08/11/23

Signed: _____

Anthony Moen
Kitchen Manager

Signed: _____

8010

651-201-4500
health.foodlodging@state.mn.us

Report #: 8010211173

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	1	Date	10/06/21
No. of Repeat RF/PHI Categories Out	0	Time In	10:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Garden House Estates	1 Riverside Drive	Duluth, MN	55808	2186280271

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
N001808		Full		H

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 10/06/21

Inspector (Signature)