DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF EXTENED CONDITIONAL LICENSE

Electronically Delivered
November 2, 2022

Administrator
Sugar Brook Villa
20868 Sugar Hills Road
Cohasset, MN 55721

RE: Conditional License Number 407190
Health Facility Identification Number (HFID) 30400
Project Number(s) SL30400015, HL304002767M/4697C, HL304002583M/4399C and HL304002602M/4366C

Dear Administrator:

The Minnesota Department of Health (MDH), State Evaluation Team completed a follow-up evaluation on October 18, 2022, for the purpose of assessing compliance with state licensing statutes. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the June 16, 2022, licensing evaluation.

In addition, MDH, State Rapid Response Team completed a complaint evaluation on September 28, 2022, complaint evaluations HL304002767M / 4697C, HL304002583M / 4399C and HL304002602M / 4366C and found two harm level violations (tag identification 1760 (S/L=G) and tag identification 2310 (S/L=H)). Based on the complaint evaluation results, you continue to be found not in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, the current conditional license will be extended by an additional 60 days. The extension is due to expire on **January 1, 2023.**

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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to the October 18, 2022, follow-up evaluation:

St - 0 - 0800 - 144g.45 Subd. 2 (a) (4) - Fire Protection And Physical Environment - $500.00

If you have any questions related to the October 18, 2022, follow-up evaluation or the conditions applied to your license, please contact Casey DeVries at:

Phone: 651-201-5917
Email: casey.devries@state.mn.us.

Further, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to the September 28, 2022, complaint evaluation:

St - 0 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

If you have any questions related to the September 28, 2022, complaint evaluation, please contact Carrie Euerle at:

Phone: 651-242-8846
Email: carrie.euerle@state.mn.us

The total amount you are assessed is $6,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.

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

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

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

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.

Conditional License Issued:
MDH is issuing Sugar Brook Villa an extension to the conditional assisted living facility license by an additional 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 calendar days, MDH will conduct a follow-up complaint evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up complaint evaluation, MDH will determine if Sugar Brook Villa has achieved substantial compliance.

The following conditions will remain in effect through the extended conditional license period and apply to the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the extended conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **Consultant:** Sugar Brook Villa will continue to contract with the MDH approved RN to provide consultation. The RN consultant must continue to have access to all resident(s) receiving services from Sugar Brook Villa. The RN will continue to report to MDH until MDH notifies Sugar Brook Villa and the RN consultant about a change. Sugar Brook Villa will continue to be responsible for the expense of the contract with the RN.

c. **Reports:** The RN consultant will provide MDH with regular reports on a weekly basis. Each report will be electronically submitted to Casey DeVries, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at casey.devries@state.mn.us or by phone at 651-201-5917 (office) with questions about reports. The content of the reports will continue to include information such as:

   i. Progress towards correction of licensing orders;
   ii. Observations of staff delivering assisted living services and the level of competency observed;
   iii. Conversations with residents and family members about satisfaction with assisted living services;
   iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
   v. Overall impressions about the quality of the assisted living services delivered;
   vi. Overall impressions about the dignity with which the residents and their family members are treated;
   vii. Concerns; and
   viii. Any other information requested by the Department or considered important by the RN consultant(s).

d. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Sugar Brook Villa to correct the violations cited during the complaint evaluation as well as to determine the overall practice of Sugar Brook Villa in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

e. **Follow-up Evaluation:** At the time of the follow-up complaint evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

f. **Corrective Action Plan:** Sugar Brook Villa will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
   i. A statement of the concern
   ii. A description of what will happen to correct the concern
   iii. A target date for when each correction will be complete
   iv. Who is responsible to make sure it happens
   v. Current status of correction work
   vi. Description of a plan to monitor and ensure ongoing compliance for each corrected order

Results of Follow-Up Survey During the Extended Conditional License Period:
MDH will determine if Sugar Brook Villa is in substantial compliance based on the results of the follow up complaint evaluation. MDH will make this determination within the 60-day conditional license period. If MDH determines Sugar Brook Villa is in substantial compliance on the follow up complaint evaluation, MDH will remove the conditions from Sugar Brook Villa's assisted living facility license, and Sugar Brook Villa will correct violations identified during the evaluation to come into substantial compliance. If MDH determines Sugar Brook Villa is not in substantial compliance, MDH may take additional enforcement action against Sugar Brook Villa and employ any of the enforcement tools listed in Minn. Stat. § 144G.20, up to and including immediate temporary suspension and revocation.

Request a Hearing:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing should be addressed to:

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this notice and the results of this visit with the President of your organization's Governing Body.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

mpm/HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 3, 2022

Administrator
Sugar Brook Villa
20868 Sugar Hills Road
Cohasset, MN 55721

RE: Project Number(s) HL304003065M/HL304004985C

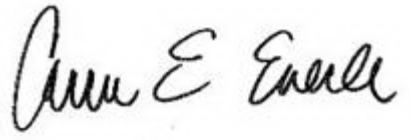
Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 28, 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 no 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 no violations. The Department of Health documents the state licensing correction orders using federal software. Please disregard the heading of the fourth column that states, "Provider's Plan of Correction." A plan of correction is not required.

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,



Carrie Euerle, Interim, Supervisor
State Rapid Response Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 651-242-8846 Fax: 651-281-9796

mpm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30400	A. BUILDING: _____ B. WING _____	R 10/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR BROOK VILLA	20868 SUGAR HILLS ROAD COHASSET, MN 55721

(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: SL30400015-1 On October 17, 2022, through October 18, 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 June 16, 2022. At the time of the survey, there were ten active residents receiving services under the Assisted Living license. As a result of the revisit, correction orders 0800 and 1470 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}	No further action required for tag 0480.	
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of	{0 800}		

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{0 800}	Continued From page 2 the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 17, 2022, between 11:15 a.m. and 12:15 p.m, survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed that the fire sprinkler system inspection tag was dated 06-21-21. On October 17, 2022, at 1:45 p.m., during the exit interview with the LALD-A, the findings were confirmed. The LALD-A explained that they were unsure why the company that had been performing these annual inspections had not been out yet to complete this. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 800}		
{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;	{01470}		

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

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{01470}	Continued From page 4	{01470}		

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 interview and record review, the licensee failed to ensure employees received orientation to 144G licensing requirements for two of five employees (unlicensed personnel (ULP)-E 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, 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-E
ULP-E was hired on November 1, 2005, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

ULP-D
ULP-D was hired on July 6, 2020, under the comprehensive home care license and began providing assisted living services on August 1,

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{01470}	Continued From page 5 2021. ULP-E and ULP-D's records lacked the following required orientation content: - an overview of this chapter; On October 18, 2022, at approximately 9:15 a.m., licensed assisted living director (LALD)-A confirmed ULP-E and ULP-D had not completed the assisted living overview of the statutes training requirements for 144G as noted above and stated, "we haven't gotten that far yet." The licensee's 5.01 Orientation of Staff and Supervisors and Content policy dated July 19, 2022, indicated orientation must be completed once for each staff person and would include an overview of the appropriate Assisted Living statutes and rules. No further information was provided.	{01470}		

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL304002602M, HL304004366C, HL304002583M/ HL304004399C, HL304002767M/HL304004697C, and HL304003065M/ HL304004985C. On September 28, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were ten (10) residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL304002767M/HL304004697C and HL304002583M/ HL304004399C, tag identification 2310. The following correction orders are issued for HL304002602M/HL304004366C, tag identification 1760, 1840.	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.	

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01760	Continued From page 1	01760		
01760 SS=G	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 interview and record review, the licensee failed to ensure medications were administered as prescribed for one of one resident (R3) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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 diagnoses included type two diabetes and adjustment disorder with depressed mood.	01760		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR BROOK VILLA	20868 SUGAR HILLS ROAD COHASSET, MN 55721

(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
01760	Continued From page 2	01760		

R3's service plan, dated July 21, 2022, indicated the resident received the following services: assistance with dressing, grooming, bathing, transfers, and medication administration.

On August 20, 2022, R3's hospice medical records indicated facility staff called to report the patient was restless and anti-anxiety medications had not been effective. The hospice progress note indicated the staff were directed to give 2 milligrams (mg) hydromorphone (pain medication) with Haldol (an anti-anxiety medication). The hospice note indicated the hospice nurse "lives out in the country and has no high speed internet, resulting in the telephone and computer not syncing." The note indicated that during the call, the hospice nurse's computer said the hydromorphone dose was 2 mg and after it was synced, it displayed the order for 1 mg. Once the hospice nurse noticed the mistake, he called the facility but the 2 mg dose had already been given to R3.

The resident's facility medication administration record (MAR) indicated the resident had an order for 1 mg of hydromorphone (pain medication) to be given every hour as needed for pain. The resident's narcotic log indicated the resident received 2 mg of hydromorphone on August 20, 2022, at 4:40 p.m.

On August 21, 2022, the resident's hospice medical records indicated the facility nurse called hospice staff due to concerns the resident had been getting antianxiety and pain medications every two hours over the night shift and seemed to be lethargic. The hospice progress notes indicate the resident's oxygen was reported to be 85% (normal is 90%-100%). The nurse practitioner was contacted who gave an order to

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	30400	A. BUILDING: _____ B. WING _____	C 09/28/2022

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check the resident's vital signs (blood pressure, respirations, pulse, oxygen saturation, temperature) every hour until the resident woke up. The resident was also started on supplemental oxygen at 2 liters per minute.

On September 28, 2022, at 1:30 p.m., licensed practical nurse (LPN)-B stated she had not been notified the resident was restless and she was not updated by staff that hospice directed to give the PRN medications. LPN-B stated when she came in the next morning (August 21, 2022), the resident "was snowed, not waking up," which prompted her to update hospice and have the resident's vital signs checked.

On September 30, 2022, at 12:30 p.m., licensed assisted living director (LALD)-E stated she worked the overnight shift of August 20, 2022. LALD-E stated the resident had been restless so hospice staff were notified and they were directed to give some as needed medications. LALD-E stated she felt the nurse overreacted and she didn't think the monitoring the next day was necessary because they had an order to give those medications and he wasn't restless anymore.

On September 30, 2022, at 1:15 p.m., hospice nurse (HN)-F confirmed the hospice nurse working on August 20, 2022, told staff to give 2 mg of pain medication instead of his scheduled 1 mg. HN-F confirmed the nurse's computer did not sync so he was not aware the order had recently been decreased to 1 mg.

On October 14, 2022, at 1:05 p.m., LALD-E stated she was not aware R3 had received 2 mg of hydromorphone instead of his ordered 1 mg of hydromorphone on August 20, 2022. LALD-E

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01760	Continued From page 4 stated hospice staff have the say on what's given and staff would follow what hospice staff directed to give. LALD-E stated the staff member who administered the 2 mg dose, ULP-D, was trusting the hospice nurse was giving her the right information when he said to give 2 mg of hydromorphone instead of the 1 mg indicated in the resident's current orders and MAR. LALD-E stated ULP-D likely didn't think it was an order change because the order did read "hydromorphone HCl Tablet 2 mg: Give 1 mg by mouth every 1 hour as needed for pain. 1 mg= half tab." LALD-E stated since the order said 2 mg in it, despite the order saying to give half a tab for 1 mg, it wasn't really a medication error. LALD-E stated there had been a lot of changes with R3's medications that week so she didn't think it was anything different when she gave the 2 mg instead of what was listed on the MAR. The licensee's Medication Error policy, dated July 13, 2022, indicated if a medication error occured, staff would document, track, and resolve medication errors for quality improvement. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
01840 SS=D	144G.71 Subd. 15 Verbal prescription orders Verbal prescription orders from an authorized prescriber must be received by a nurse or pharmacist. The order must be handled according to Minnesota Rules, part 6800.6200. This MN Requirement is not met as evidenced by:	01840		

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01840	Continued From page 5 Based on interview and record review, the licensee failed to ensure verbal prescription orders from an authorized prescriber were received by a nurse or pharmacist for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included type two diabetes and adjustment disorder with depressed mood. R3's service plan, dated July 21, 2022, indicated the resident received the following services: assistance with dressing, grooming, bathing, transfers, and medication administration. R3's signed prescriber orders indicated the resident had an order for 1 milligram (mg) of hydromorphone to be given every hour as needed for pain. On August 20, 2022, hospice medical records indicated unlicensed personnel (ULP)-D called hospice to report the patient was restless and as needed (PRN) lorazepam (medication for anxiety) given two hours prior to the call, was not effective. The hospice progress note indicated ULP-D was directed to give 2 mg hydromorphone with haldol (a medication for anxiety) and if the resident was still restless in two hours, to give	01840		

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01840	Continued From page 6	01840		

hydromorphone (pain medication) with lorazepam and to call back if not successful. The hospice note indicates the hospice nurse "lives out in the country and has no high speed internet," resulting in the telephone and computer not syncing. The note indicated that during the call, the hospice nurse's computer said the hydromorphone dose was 2mg and after it was synced, it displayed as a 1 mg dose. Once the hospice nurse noticed the mistake in what he directed staff to do, he called the facility but the 2 mg dose had already been given according to the progress note. A nurse practitioner for hospice was contacted and informed of the med error by the hospice nurse and the progress note indicates the nurse practitioner was "thankful for the call and said it would be ok."

The resident's facility medication administration record (MAR) indicated the resident received 1 mg of hydromorphone at 4:48 p.m. The resident's narcotic log indicated the resident received 2mg of hydromorphone at 4:40 p.m.

On October 14, 2022, at 1:05 p.m., LALD-E stated she was not aware R3 had received 2 mg of hydromorphone instead of his ordered 1 mg of hydromorphone on August 20, 2022. LALD-E stated that hospice staff are able to give phone orders and the usual procedure would be for the ULP to contact the facility nurse with the order so they can put it in the computer. LALD-E confirmed "that wasn't the case this day." LALD-E stated hospice staff have the say on what's given and staff would follow what hospice staff directed to give. LALD-E stated ULP-D was trusting the hospice nurse was giving her the right information when he said to give 2 mg of hydromorphone instead of the 1 mg indicated in the resident's current orders and MAR. LALD-E stated ULP-D

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01840	Continued From page 7 likely didn't think it was an order change because the order did read "hydromorphone HCl Tablet 2 mg: Give 1 mg by mouth every 1 hour as needed for pain. 1 mg= half tab." LALD-E stated since the order said 2 mg in it, despite the order saying to give half a tab for 1 mg, it wasn't really a medication error. LALD-E stated there had been a lot of changes with R3's medications that week so she didn't think it was anything different when she gave the 2 mg instead of what was listed on the MAR. A policy on procesing orders was requested, but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01840		
02310 SS=H	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 interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for two of three residents (R1, R2) when the nurse was not notified of changes in condition. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	02310		

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not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a 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
R1's diagnoses included type two diabetes and Alzheimer's disease.

R1's service plan dated July 19, 2022 , indicated the resident received the following services: assistance of 1 to 2 with dressing, grooming, bathing, feeding, transfers with two people using a hoyer lift, daily medication administration, and weekly housekeeping and laundry.

The resident's most recent assessment, dated September 8, 2022, indicated the resident was severely cognitively impaired and nonverbal.

A progress note entered by unlicensed personnel (ULP)- C on August 26, 2022, indicated she noticed hard, compacted ear wax/debris in the resident's ear canal that was blocked with a dark brown mass that was very hard. ULP-C documented " ...I removed it [ear wax] by safely grasping the end with a tweezer and pulling it out. Once I removed the mass from the front ear, I noticed the end that was attached to the rest of the compaction had some semi-fresh blood. The dark brown compaction appeared to be dried blood that accumulated in the ear canal (not diagnosed by a medical physician) I found [the resident's] right ear had the same findings as the

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left ....I did not proceed further due to prevent injury to the ear and wouldn't go past the ear canal. Follow up needed." ULP-C did not report her findings to the nurse.

A progress note entered by registered nurse (RN)-G on August 26, 2022, indicated staff getting the resident ready for dinner noted blood in both of the resident's ears. RN-G assessed the resident's ears and due to the presence of blood in the ear canal with unknown cause, the resident was sent to the emergency room for further evaluation.

The resident's emergency room records indicate a CT scan was completed. The emergency room records note the resident had dried blood to both ears, both ears right tympanic membrane appeared to be perforated, and pooling blood in both ears was noted. No external ear trauma was noted. The resident was diagnosed with bilateral acute otitis media (middle ear infection) and bilateral externa media (infection of the outer opening of the ear and ear canal). The resident was prescribed antibiotics and discharged back to the facility.

On September 28, 2022, at 1:10 p.m., licensed practical nurse (LPN)-B stated ULP-C did not report the concerns with the resident's ears having built up wax to her. LPN-B stated she only found out afterwards when staff on the evening shift called to report blood coming from the resident's ears. LPN-B stated she later found bloody tweezers in the laundry room sink and discovered ULP-C had used the tweezers to clean out excess wax from the resident's ears.

On September 29, 2022, at 11:20 a.m., ULP-C confirmed she had used tweezers to clean ear

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wax from both of the resident's ears. ULP-C stated she knew she shouldn't have used the tweezers and had not been trained to remove ear wax that way. ULP-C stated she was in a hurry when she was leaving work and forgot to update the nurse about what she had done.

On September 29, 2022, at 1:50 p.m., the physician's assistant (PA)-H who treated the resident in the emergency department stated he couldn't say what was the cause of the ruptured ear drums. PA-H stated an ear infection could cause the rupture, but the tweezers could have also led to the rupture.

On October 17, 2022, at 12:35 p.m., primary care provider (PCP)-I stated she didn't believe an infection led to the ruptured ear drums. PCP-I stated she had been following the healing of the resident's ears since she returned from the ER and felt some of the abrasions in her ear had been caused by the tweezers. PCP-I stated one of the resident's ear drums had healed but she was still monitoring and treating the other.

R2
R2's diagnoses included hypertension (high blood pressure).

R2's service plan dated July 13, 2022, indicated the resident received the following services: assistance with dressing, grooming, bathing, daily medication administration, and weekly housekeeping and laundry.

The resident's most recent assessment, dated August 26, 2022, indicated the resident was bed bound and receiving hospice services.

A progress note entered by ULP-D on August 26,

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02310	Continued From page 11 2022 at 11:37 a.m., indicated R2's oxygen was 76% (normal range is 90-100%). On September 28, 2022, at 1:25 p.m., LPN-B confirmed she was not notified the resident's oxygen level had dropped. LPN-B stated R2 was on hospice services but he wasn't actively dying. LPN-B stated the resident had not had any dips in his oxygen levels since he moved in to the facility but did have an order for supplemental oxygen if his oxygen went below 90%. LPN-B stated an internal investigation was not done as to why staff did not notify the nurse and felt the staff member got overwhelmed trying to complete other duties that morning. On September 28, 2022, at 2:15 p.m., ULP-D stated she had checked R2's oxygen the morning of August 26th and when she got the low reading, she went and told LALD-E. ULP-D stated she knew she should have called the nurse and stated LALD-E told her she should call the nurse. ULP-D stated she put some oxygen on the resident but since she was in the middle of serving breakfast to other residents and doing the medication pass that morning, she forgot to call the nurse. ULP-D stated she knew the oxygen was low and knew she should have called the nurse but just got busy and didn't remember to notify the nurse until she saw her walk in the building later that day. On September 29, 2022, at 11:20 a.m., ULP-C stated she was working the morning of August 26th with ULP-D. ULP-C stated she noticed the resident had a "complete 180 change in condition from the day before and was unresponsive...we were wondering what the heck was going on." ULP-C stated ULP-D doesn't "work on meds a lot because she gets overwhelmed and her brain	02310		

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can't respond and act fast and I'm guessing everything going on and trying to take care of the resident, she forgot." ULP-C stated ULP-D had notified her of the resident's low oxygen and she had suggested to ULP-D that she call the nurse and let her know.

On September 30, 2022, at 9:00 a.m., hospice nurse (HN)-F stated the resident had a need for supplemental oxygen before admitting to hospice but had not had any episodes of low oxygen recently. HN-F stated once they were notified of the episode of low oxygen, they assessed the resident and did not make any changes to his care plan. HN-F stated they were not surprised the resident had a rapid change in condition as he had started to decline and expressed that he was "ready to go."

On September 30, 2022, at 12:00 p.m., LALD-E confirmed ULP-D reported R2's low oxygen to her the morning of August 26, 2022. LALD-E stated she showed ULP-D how to chart it and stated she told the ULP to report the change to the nurse. LALD-E stated she was busy that morning and did not check in to make sure the nurse was notified. LALD-E stated she didn't see the drop in oxygen as a change in condition, "it's the ups and downs of the dying process." LALD-E confirmed no investigation or formal education was completed with staff after these incidents occurred. LALD-E stated, "It's not that we don't have the system in place, it's on them, it's the individuals job to follow through and report things to the nurses. I tell my staff all the time you need to tell the nurse or make a progress note to cover your ass so if the nurse doesn't follow through it's not on you."

On September 30, 2022, at 1:50 p.m., RN-G

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02310	Continued From page 13 stated she was on call but not onsite on August 26, 2022. RN-G stated LPN-B notified her after she went to the facility that afternoon and that it would have been her expectation staff called her or LPN-B as soon as they noticed the resident's oxygen levels dropped below a normal range. R2 died on August 28, 2022. The resident's death certificate indicated the cause of death was a hemorrhagic stroke. A policy on notification of the nurse for resident change in conditions was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 26, 2022

Administrator
Sugar Brook Villa
20868 Sugar Hills Road
Cohasset, MN 55721

RE: Initial License Number 407190
Health Facility Identification Number (HFID) 30400
Project Number(s) SL30400015

Dear Administrator:

On October 20, 2022, The Minnesota Department of Health (MDH) received a correspondence via email from Melissa Ingvalson, LALD, at your organization requesting a condition currently being enforced under a Conditional Letter, be rescinded. Upon further review of your organization's request by staff of this Department, the following condition is rescinded effective October 21, 2022:

- No New Admissions

The remaining conditions detailed in the original Conditional Letter dated August 3, 2022, will continue to be enforced until a follow-up evaluation can be conducted and substantial compliance is achieved.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter with the President of your organization's Governing Body. If you have any questions, please contact Casey DeVries at 651-201-5917.

Sincerely,

Maria King

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

August 3, 2022

Administrator
Sugar Brook Villa
20868 Sugar Hills Road
Cohasset, MN 55721

RE: Conditional License Number 407190
Health Facility Identification Number (HFID) 30400
Project Number SL30400015

Dear Administrator:

The Minnesota Department of Health (MDH) completed an initial evaluation on June 16, 2022, for the purpose of assessing compliance with state licensing statutes and to determine issuance of an initial license to the above mentioned provider. Based on the initial evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is issuing a 90 day conditional license due to expire on **November 1, 2022**.

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

St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements - $3,000.00
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00

The total amount you are assessed is $9,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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**.

Conditional License Issued:
MDH will issue Sugar Brook Villa a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Sugar Brook Villa is in compliance.

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

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. No new admissions: Sugar Brook Villa will not admit any new residents under its conditional assisted living facility license until the MDH removes the "no new admissions" condition. Sugar Brook Villa must provide the Department:

i. A list of the names and birthdates of any individuals Sugar Brook Villa is currently in the process of admitting. These individuals will be able to continue the admittance process.

ii. A list of all current residents by location including:
1. Name and birthdate of each resident
2. Physical location of each resident
3. Current payment source for services
4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. Consultant: Sugar Brook Villa will contract with an RN to provide consultation concerning all resident(s) to whom Sugar Brook Villa provides licensed assisted living services under the conditional license. <u>The consultant must have access to all resident(s) receiving services from Sugar Brook Villa. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH</u>. The RN must not have any affiliation with Sugar Brook Villa and MDH must review the RN's credentials and approve the selection. Sugar Brook Villa is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Sugar Brook Villa in an effort to help Sugar Brook Villa align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward compliance and/or concerns about observations. Sugar Brook Villa will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Sugar Brook Villa and the RN consultant about a change. Each report will be electronically submitted to Casey DeVries, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at casey.devries@state.mn.us. Casey DeVries can be reached at 651-201-5917 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of licensing orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Sugar Brook Villa to correct the violations cited during the evaluation as well as to determine the overall practice of Sugar Brook Villa in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. Follow-up Evaluation: At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. Corrective Action Plan: Sugar Brook Villa will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing compliance for each corrected order

Results of Follow-Up Survey During the Conditional License Period:
MDH will determine if Sugar Brook Villa is in compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license period. If MDH determines Sugar Brook Villa is in substantial compliance on the follow up evaluation, MDH will

remove the conditions from Sugar Brook Villa's assisted living facility license, and Sugar Brook Villa will correct violations identified during the evaluation to come into full compliance. If MDH determines Sugar Brook Villa is not in substantial compliance, MDH may take additional enforcement action against Sugar Brook Villa, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

Request a Hearing:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing should be addressed to:

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this notice and the results of this visit with the President of your organization's Governing Body.

If you have any questions, please contact Casey DeVries directly at: 651-201-5917.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30400	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR BROOK VILLA	20868 SUGAR HILLS ROAD COHASSET, MN 55721

(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, these correction orders have 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: SL30400015-0 On June 14, 2022, through June 16, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were eleven (11) residents receiving services under the Assisted Living license. On June 15, 2022, an immediate correction order was identified for SL30400015-0, tag identification 0820 and was issued to the licensee on June 24, 2022. On July 14, 2022, an immediate correction order was issued for SL30400015-0, tag identification 1750. On July 15, 2022, an immediate correction order was issued for SL30400015-0, tag identification	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 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 SUBDIVISION 1-3.	

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0 000	Continued From page 1 0495. On July 19, 2022, the immediacy of correction order 1750 was removed, however, non-compliance remained at a level 3, scope of widespread violation.	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4;	0 250		

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0 250	Continued From page 2 (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 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 observation, interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 250		

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0 250	Continued From page 3 or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 14, 2022, at approximately 11:30 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building (s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults.	0 250		

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0 250	Continued From page 4 - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally	0 250		

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0 250	Continued From page 5 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 my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by licensed assisted living director (LALD)-A on May 4, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - handling complaints regarding staff or services provided by staff; - infection control practices; - conducting initial evaluations of residents' needs	0 250		

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0 250	Continued From page 6 and the providers' ability to provide those services; - 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 resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - reminders for medications, treatments, or exercises, if provided; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; - supervision of registered nurses and licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. On June 16, 2022, at 10:29 a.m., LALD-A confirmed the licensee provided contracted assisted living services as noted above but failed to develop and implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0250, 0430, 0470, 0480, 0485, 0495, 0510, 0550, 0580, 0630, 0640, 0660, 0680, 0730, 0770, 0780, 0800, 0810, 0820, 0900, 0910, 0920, 0930, 0940, 1360, 1410, 1460, 1470, 1490, 1610, 1650, 1690, 1730, 1750, 1770, 1880, 1890, 1930, 1940, 1950, 2240 and 3390, indicating the licensee's understanding of the Minnesota	0 250		

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0 250	Continued From page 7 statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=B	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). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to three of four residents	0 430		

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0 430	Continued From page 8 (R1, R2, 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 R1 admitted for service on November 1, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's service plan dated November 5, 2019, indicated R1 received services including medication administration, oxygen monitoring, compression stockings assistance, bathing, grooming, toileting, ambulation, transfers and dressing. R1's record 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; and - 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. R2	0 430		

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0 430	Continued From page 9 R2 admitted for services on July 25, 2020, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's untitled document with a print date of June 14, 2022, indicated R2 received services for medication management, bathing, dressing, bowel/bladder monitoring, meals, mobility, transfers, blood (sugar) checks, toileting, grooming, housekeeping and laundry. R2's record 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; and - 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. R3 R3 admitted for services on October 20, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R3's Service Plan with initiation date of October 21, 2021, indicated R3 received services for medication administration bathing, treatments as ordered, orientation, grooming, dressing, meals, assistance with leg elevation, laundry and housekeeping. R3's record lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living	0 430		

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0 430	Continued From page 10 licenses available and the category of license held by the facility; and - 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. On June 16, 2022, at approximately 10:29 a.m., licensed assisted living director (LALD)-A stated licensee was in the process of getting the uniform disclosure of assisted living services and amenities (UDALSA) out to families for a signature. LALD-A stated "the originals went out the door to the families. I just need signatures. I know they got it; I just don't have them." LALD-A confirmed R1, R2 and R3's records lacked documentation a UDALSA had been reviewed or received. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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	0 470		

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	30400	A. BUILDING: _____ B. WING _____	06/16/2022

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0 470	Continued From page 11 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 develop a staffing plan to determine staffing levels to meet the needs of all residents and to ensure the plan was implemented and posted as required. This had the potential to affect all 11 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 470		

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0 470	Continued From page 12 The licensee held an assisted living facility license and was licensed for a capacity of 12 residents, with a current census of 11 residents. During the facility tour on June 14, 2022, at approximately 11:15 a.m., with clinical nurse supervisor (CNS)-B, the surveyor observed the lack of a posted staffing plan. CNS-B stated licensed assisted living director (LALD)-A "takes care of the scheduling." The surveyor asked CNS-B if she participated in the scheduling of staff or had developed a staffing plan for the facility. CNS-B stated LALD-A "takes care of all of that. I don't know anything about a staffing plan." On June 16, 2022, at approximately 10:30 a.m., LALD-A confirmed there was no staffing plan or matrix used by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 13 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated June 15, 2022, 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	0 485		

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0 485	Continued From page 14 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 and interview, the licensee failed to ensure menus were prepared one week in advance and available to the residents. This had the potential to affect all residents receiving services. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour with clinical nurse supervisor (CNS)-B, on June 14, 2022, at approximately 11:15 a.m., the surveyor observed	0 485		

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0 485	Continued From page 15 one tattered menu in a plastic sleeve posted on the wall above the kitchen sink. On June 14, 2022, at approximately 11:15 a.m., licensed assisted living director (LALD)-A stated a monthly menu was kept on the wall above the kitchen sink for staff to use and had not been provided to the residents. LALD-A stated it was a revolving menu with a lot of fresh seasonal foods used. LALD-A explained fresh fruit is an option served with every meal and the fruit choice is based on "the fruit and vegetable in season." On June 14, 2022, at approximately 11:15 a.m., LALD-A confirmed the menu posted on the wall was the monthly menu format used and available to view by residents, however, was not provided to residents. Additionally, residents would need to specifically ask a staff member to view the menu and would be reliant on staff to give them access to the menu, due to the menu's location. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 495 SS=I	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to provide staff access to an on-call registered nurse (RN) 24 hours per day, seven days per week. This had the potential to	0 495		

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0 495	Continued From page 16 affect all residents receiving assisted living services. This resulted in an immediate correction order issued on July 15, 2022, at approximately 6:15 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked staff access to an on-call RN, 24 hours per day, seven days per week. On July 15, 2022, the licensee's staffing schedule noted the RN's last scheduled day at the facility was June 24, 2022. During an interview on July 15, 2022, at approximately 3:00 p.m. clinical nurse supervisor (CNS)-B stated she had been to the licensee's establishment twice since June 22, 2022. Additionally, during the interview CNS-B stated she was on a trip to "the cities" at the time of interview (175 miles one-way) and would not be available to the facility. CNS-B stated she would no longer be on-call since turning in a notice to end employment with licensee on June 22, 2022. CNS-B gave an example of when recently sick with COVID-19 in June, there was no back up plan to have a RN available to assess residents for a change in condition.	0 495		

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0 495	Continued From page 17 During interview on July 15, 2022, at approximately 3:40 p.m., licensed assisted living director (LALD)-A stated CNS-B was the facility's only RN and the facility had been trying to hire another RN. LALD-A stated she was aware CNS-B had given notice to end employment on June 22, 2022, and was not available 24 hours a day, seven days a week to provide RN services to residents or staff of the facility. Additionally, LALD-A stated she was aware CNS-B was not available to take call in the event of an emergency or change of condition. LALD-A stated she was available to assist with call along with the facilities licensed practical nurse (LPN)-C. LALD-A verified the facility had no back up plan to have an on-call RN available, such as when CNS-B was sick or unable to assess residents for changes in condition. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 495		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision.	0 510		

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0 510	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19. The licensee failed to ensure staff wore recommended personal protective equipment while working in the facility. The deficient practice had the potential to affect all residents, employees and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: EYE PROTECTION On June 14, 2022, at 10:30 a.m., a surveyor from the Minnesota Department of Health (MDH) entered the facility and was greeted by licensed practical nurse (LPN)-C. LPN-C wore a medical grade mask, no protective eyewear while screening the surveyor for Covid-19. Unlicensed Personnel (ULP)-D On June 14, 2022, throughout the morning/afternoon shift, the surveyor observed ULP-D wore a medical grade mask and no protective eyewear while entering and exiting resident rooms, providing assistance to residents in common areas and interacting with coworkers	0 510		

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0 510	Continued From page 19 and visitors. LPN-C/CNS-B On June 14, 2022, at approximately 11:00 a.m., the surveyor toured the facility with LPN-C and clinical nurse supervisor (CNS)-B. Throughout the tour of the facility, LPN-C and CNS-B wore a medical grade mask, no protective eyewear. The surveyor observed interactions between LPN-C, residents and coworkers throughout the day in resident areas with residents present, and LPN-C wore a medical grade facemask, no protective eyewear. Licensed Assisted Living Director (LALD)-A On June 14, 2022, at approximately 11:30 a.m., the surveyor observed LALD-A in the dining room interacting with residents and staff preparing for lunch. LALD-A wore a medical grade facemask, no protective eyewear. RESIDENT SCREENING On June 14, 2022, at approximately 11:40 a.m., the surveyor asked LPN-C what the resident Covid-19 screening process was for residents. LPN-C stated, "we screen and test if a resident becomes symptomatic." No resident Covid-19 screening logs were available for review by the surveyor. On June 15, 2022, at 10:00 a.m., the surveyor conducted an interview with LPN-C. The surveyor asked LPN-C if the facility had personal protective equipment for use by staff. LPN-C stated they had face sheilds. LPN-C stated, "I've been here since April (2022), and I've never had to wear the face shield." On June 15, 2022, at approximately 10:30 a.m., the surveyor interviewed CNS-B and confirmed	0 510		

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0 510	Continued From page 20 the lack of protective eyewear worn by ULP-D, LPN-C, LALD-A and all other staff the surveyor observed interacting with residents in the building. The surveyor asked CNS-B who was responsible for monitoring infection control standards and providing guidance to staff, CNS-B stated, "[LALD-A's name], that's who tells us what to wear. She calls the shots; this is her facility." The surveyor provided CNS-B with the link to the Centers for Disease Control and Prevention (CDC) website for knowledge of community transmission levels and required personal protective equipment (PPE) use. The Minnesota Department of Health (MDH) COVID-19 PPE and Source Control Grids for Congregate Care Settings by Community Transmission Levels dated April 7, 2022, indicated with high community transmission levels, protective eyewear and medical grade masks were to be worn by staff to prevent unseen spread of COVID-19 in a facility. The guidance recommended eye protection when staff were in resident care areas. On June 15, 2022, at approximately 8:56 a.m., the surveyor confirmed the Centers for Disease Control and Prevention (CDC) county tracker indicated covid transmission levels were high within the county the facility is located. The licensee's Covid-19 Preparedness Plan policy, undated, and signed by LALD-A, indicated licensee would implement safety measures based on the CDC and MDH guidelines to remain compliant. No further information provided. TIME PERIOD FOR CORRECTION: Two (2)	0 510		

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0 510	Continued From page 21 days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and 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 the required information related to the grievance procedure, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all 11 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 550		

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0 550	Continued From page 22 On June 14, 2022, during the facility tour at approximately 11:00 a.m., the surveyor observed facility common areas and noted the lack of required posting of the licensee's grievance procedure and information related to reporting suspected maltreatment to MAARC. In addition, there was no posting of 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, or any information for reporting suspected maltreatment to MAARC. On June 14, 2022, at approximately 11:20 a.m., licensed assisted living director (LALD)-A confirmed the content noted above was not posted as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time	0 580		

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0 580	Continued From page 23 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 11 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 June 14, 2022, at approximately 1:40 p.m., licensed assisted living director (LALD)-A stated the licensee had not developed a quality management program and there was no current documentation of a quality management activity. LALD-A stated she was unaware of the requirement pertaining to quality management. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 580		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an	0 630		

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0 630	Continued From page 24 individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan with the required content for three of three residents (R1, R2, 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included heart failure. R1's service plan dated November 5, 2019, indicated R1 received services including medication administration, oxygen monitoring, compression stockings assistance, bathing, grooming, toileting, ambulation, transfers and dressing.	0 630		

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0 630	Continued From page 25 R1's medical record lacked an individual abuse prevention plan. R2 R2's diagnoses included type II diabetes. R2's service plan dated January 1, 2022, indicated R2 received services which included medication administration, meals, assistance with activities of daily living, housekeeping and laundry services. R2's medical record lacked an individual abuse prevention plan. R3 R3's diagnoses included frontal dementia. R3's Service Plan with initiation date of October 21, 2021, indicated R3 received services for medication administration bathing, treatments as ordered, orientation, grooming, dressing, meals, assistance with leg elevation, laundry and housekeeping. R3's medical record lacked an individual abuse prevention plan. On June 16, 2022, at 10:30 a.m., licensed assisted living director (LALD)-A confirmed R1, R2 and R3 lacked individual abuse prevention plans and stated, "all that stuff, those things were supposed to be included with the assessments." The licensee's Abuse Prevention Plan policy, undated, indicated the plan and related policies and procedures would be reviewed a minimum annually for effectiveness and compliance with applicable Federal, State and local law. The	0 630		

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0 630	Continued From page 26 policy further indicated the plan would include seven key components identified by Medicare and Medicaid federal regulations. The policy did not address assisted living regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information to include: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; and (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had the potential to affect all current	0 640		

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0 640	Continued From page 27 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour on June 14, 2022, at approximately 11:15 a.m., the surveyor observed the common areas and near telephones provided by the assisted living lacked the required posting for the 911 emergency number and the information for reporting suspected maltreatment to MAARC. On June 14, 2022, at approximately 1:00 p.m., licensed assisted living director (LALD)-A confirmed the 911 emergency number was not posted on or near telephones located within the main entry area and the contact information or reporting number for MAARC was not posted in a conspicuous manner. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 28 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 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 facility risk assessment and ensure employees completed TB training for two of four employees (clinical nurse supervisor (CNS)-B, licensed practical nurse (LPN)-C) with employee records reviewed. The licensee also failed to ensure screenings for health history, symptoms and active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for three of four employees (CNS-B, LPN-C and unlicensed personnel (ULP)-D) with employee records reviewed. This had the potential to affect all 11 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 660		

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0 660	Continued From page 29 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: TB RISK ASSESSMENT During the entrance conference on June 14, 2022, at approximately 10:45 a.m., surveyor requested the facility TB risk assessment to review. CNS-B stated she was unaware of what that was, and it had not been completed. The licensee'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. Additionally, the licensee failed to provide TB training to staff as required. TB TRAINING CNS-B and LPN-C employee records lacked evidence of TB training completion at time of hire, as required. CNS-B CNS-B had a hire date of June 14, 2021, and provided supervisory and nursing assessment services for residents of the facility. On June 14, 2022, at approximately 11:20 a.m., CNS-B stated to the surveyor, "I do all the admission, 14-day and 90-day assessments." LPN-C	0 660		

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0 660	Continued From page 30 LPN-A had a hire date of April 11, 2022, and provided supervision to staff and direct nursing care to residents of the facility. On June 16, 2022, at approximately 10:00 a.m., the surveyor observed LPN-C setting up a medication caddie (pill organizer with multiple compartments set up by the time of day and day of the week) for R1. On June 16, 2022, at approximately 10:30 a.m., licensed assisted living director (LALD)-A confirmed CNS-A and LPN-C did not receive TB training upon hire, or at any other time as required. Additionally, LALD-A stated, "I know now that they need that." TB HISTORY AND SYMPTOM SCREEN CNS-B, LPN-C and ULP-D's employee records lacked evidence of completed TB health history and symptom screening and lacked evidence of baseline testing for presence of TB infection. CNS-B CNS-B had a hire date of June 14, 2021, and provided supervisory and nursing assessment services for residents of the facility. LPN-C LPN-A had a hire date of April 11, 2022, and provided supervision to staff and direct nursing care to residents of the facility. ULP-D had a hire date of July 6, 2020, to provide direct care to licensee's residents. CNS-B, LPN-C and ULP-D's employee records lacked the following as required: - documentation of a completed health history	0 660		

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0 660	Continued From page 31 and symptom screening; and - completion of a two-step TST or other evidence of TB screening such as a blood test. On June 16, 2022, at approximately 10:30 a.m., licensed assisted living director (LALD)-A confirmed CNS-A, LPN-C and ULP-D did not complete the required TB history and symptom screening, a two-step TST, or a blood test as required. Additionally, LALD-A stated, "I know now that they need that." The licensee's 6.08 Tuberculosis and Staff Screening policy dated April 2016, indicated a TB risk assessment would be completed by the RN, all staff would be educated with training regarding TB at the time of hire and all staff that share the same air space as residents would have a baseline health screening prior to providing care to residents, to include assessment for current symptoms of active TB and testing for the presence of infection with a two-step TST, single blood test, or chest x-ray. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005, 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 and a baseline TB screening should be	0 660		

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0 660	Continued From page 32 documented in the employee's record. The licensee's 6.08 Tuberculosis and Staff Screening policy, dated July 2016, indicated all staff whose essential job functions require them to work within the same air space of residents would be screened and tested for TB. The policy further indicated licensee would have an ongoing program for screening and educating staff on TB and licensee would include in licensee's infection control plan a community TB risk assessment. 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 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	0 680		

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0 680	Continued From page 33 make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content, post an emergency preparedness plan prominently and provide residents with exit diagrams. This had the potential to affect all 11 residents receiving services under the assisted living license. 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 June 14, 2022, at approximately 10:45 a.m., the surveyor requested to view the licensee's emergency preparedness plan, which was provided to and later reviewed by the surveyor. Licensee's emergency preparedness plan addressed fire, seasonal weather hazards and Covid-19. The licensee's emergency preparedness plan	0 680		

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0 680	Continued From page 34 lacked the following content and/or policies and procedures to address: - a comprehensive program to include man-made disasters, facility based (power, water etc.), infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - the facility's role in providing care and treatment at alternative sites; - the provision of subsistence needs for staff and residents; - a tracking system used to document locations of residents and staff; - an evacuation plan; - how the facility would provide a means to shelter in place for residents and volunteers; - the medical record documentation system the facility has developed to preserve resident information security and availability of records; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. In addition, the licensee lacked a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities and volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - 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	0 680		

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0 680	Continued From page 35 occupancy; and - a method of sharing information from the emergency plan with residents and their families. - development of policies/procedures to address: - evacuation plan (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; - the facility's role in providing care and treatment at alternative sites; - emergency preparedness training and testing program; and - emergency preparedness testing/annual testing requirements. On June 16, 2022, at approximately 10:30 a.m., licensed assisted living director (LALD)-A confirmed the licensee had not fully developed and implemented the facility's emergency preparedness plan/program or the Appendix-Z requirements. Additionally, LALD-A stated, "we are working on it, we're gonna work on that. That is another undertaking that will require a lot of time." The licensee's 7.01 Disaster Planning and Emergency Preparedness Plan policy dated January 2014, indicated the facility would conduct a Hazard Vulnerability Analysis (HVA) and develop a disaster plan for those events that were considered to have a high probability with high risk to include sheltering in place and evacuations. Additionally, the policy indicated staff should be trained on licensee's disaster and emergency preparedness plan at hire and	0 680		

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0 680	Continued From page 36 annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (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	0 730		

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0 730	Continued From page 37 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 a resident record included a discharge summary for one of one discharged resident (R5) with record 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 diagnosis included dementia. R5 admitted for services on December 26, 2020, under the comprehensive home care license and	0 730		

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0 730	Continued From page 38 began receiving assisted living services on August 1, 2021. R5 was discharged on June 6, 2022. R5's record lacked completion of a discharge summary. On June 14, 2022, at approximately 1:40 p.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B confirmed the licensee had not completed a discharge summary for R5. The licensee's Client Record - Mn Statute 4668.0810 policy, undated, did not address required discharge information. The policy did indicate client [resident] records would be retained for five years following discharge. No further information provided. TIME PERIOD OF CORRECTION: Twenty-One (21) days	0 730		
0 770 SS=F	144G.45 Subdivision 1 Minimum site Requirements The following are required for all assisted living facilities: (1) public utilities must be available, and working or inspected and approved water and septic systems must be in place; (2) the location must be publicly accessible to fire department services and emergency medical services; (3) the location's topography must provide sufficient natural drainage and is not subject to flooding; (4) all-weather roads and walks must be provided	0 770		

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SUGAR BROOK VILLA	20868 SUGAR HILLS ROAD COHASSET, MN 55721

(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
0 770	Continued From page 39 within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and (5) the location must include space for outdoor activities for residents. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to test the well water within the last year. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 15, 2022, at approximately 11:25 a.m., the LALD-A provided documents for review. Documents were reviewed by survey staff on June 15, 2022, between 11:25 a.m. and 11:55 a.m. A well water test report dated 10-15-18 from Pace Analytical was provided. The LALD-A confirmed during an interview, at approximately 11:45 a.m., that the well water had not been tested within the last year and that a new water test needed to be performed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 770		

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0 780	Continued From page 40	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms 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 was issued at a	0 780		

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0 780	Continued From page 41 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 15, 2022, between 10:20 a.m. and 11:25 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following: 1. When sleeping room smoke alarms in the double occupancy rooms were tested, the other smoke alarms within the dwelling unit were not activated. In the tour interview with the LALD-A, they explained that the smoke alarms were battery operated and confirmed that the alarms were not interconnected. 2. Smoke alarms were not installed in the hallways outside each separate sleeping area. In the tour interview with the LALD-A, they confirmed that smoke alarms were not installed in the hallways. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	0 800		

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0 800	Continued From page 42 repair program. This MN Requirement is not met as evidenced by: Surveyor: Leitinger, Michelle Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 15, 2022, between 10:20 a.m. and 11:25 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following: 1. The edge of one concrete septic tank lid was cracked and crumbling in the backyard. 2. Windows were not provided with screens in the resident rooms. 3. A gas fireplace was installed in the living room. A carbon monoxide detector was not observed within the facility. In the tour interview with the LALD-A, they confirmed that a gas fireplace was provided and stated that they did not know if a carbon monoxide detector was installed. On June 15, 2022, at approximately 12:15 p.m.,	0 800		

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0 800	Continued From page 43 during an interview with the LALD-A, it was confirmed that the septic tank lid required maintenance. The LALD-A confirmed that some of the windows in resident rooms were not provided with screens. The LALD-A explained that when requested by the resident, screens would be provided. The LALD-A further explained that there were concerns that windows would be left open when the air conditioning was running. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	0 810		

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0 810	Continued From page 44 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide the required plans, training, and drills for fire safety and evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 15, 2022, between 10:20 a.m. and 11:25 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed that the evacuation maps posted did not identify the location and number of resident sleeping rooms. At approximately 11:25 a.m. on June 15, 2022, survey staff requested documentation on the plans, training, and drills for fire safety and evacuation. The LALD-A stated that evacuation	0 810		

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0 810	Continued From page 45 maps were posted and that there were no additional fire safety and evacuation plans. At approximately 12:05 p.m., a Code Red - Fire Plan was provided by the LALD-A. Documents were reviewed by survey staff on June 15, 2022, between 11:25 a.m. and 12:15 p.m. 1. The Code Red - Fire Plan was not developed and maintained. a. The location and number of resident sleeping rooms were not identified. b. The former owner of the facility was referenced as a contact for instructions on how to reset the alarm. c. Fire protection procedures necessary for residents were not included. d. Procedures for resident movement, evacuation, or relocation during a fire or similar emergency were not included. e. Unique or unusual resident needs for movement or evacuation were not identified. 2. The licensee failed to provide annual fire safety and evacuation training for residents. Documentation was requested by survey staff but not provided. 3. The licensee failed to provide written documentation on employee training. No training plans or policies were provided. No employee training records were provided. 4. A policy or procedure for evacuation drills was not provided. No evacuation drill logs or schedules were included. On June 15, 2022, at approximately 12:15 p.m., during an interview, the LALD-A explained that employees were trained on fire safety and evacuation upon hire and annually. The LALD-A stated that evacuation drills were completed annually. The LALD-A confirmed that the licensee failed to provide the required content within the	0 810		

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0 810	Continued From page 46 fire safety and evacuation plans. The LALD-A additionally confirmed that the training and evacuation drill frequency requirements were not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all physical facility elements, including exit doors, do not create a distinct hazard to residents and staff. This had the potential to directly affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	0 820		

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0 820	Continued From page 47 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 June 15, 2022, between 10:20 a.m. and 11:25 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed that keypads were installed at three marked exit doors. A code needed to be entered into the keypad to open the exit doors located at the end of each hallway during the tour. In the event of evacuation, entering a code into a keypad would prevent a safe and quick exit. In the tour interview with the LALD-A, they confirmed that the exit doors required entry of a keycode to open these doors. The LALD-A explained that only some of the residents had been trained on how to use the keypads. They further explained that residents who cannot be outside unsupervised are not trained on how to use the keypad. At approximately 11:25 a.m., survey staff requested the fire safety and evacuation plans for the facility. The LALD-A stated that evacuation maps were posted and that there were no additional fire safety and evacuation plans. At approximately 12:05 p.m., a Code Red - Fire Plan was provided by the LALD-A. This plan did not include information on how to use the keypads installed at the exit doors. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 820		

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0 900	Continued From page 48	0 900		
0 900 SS=D	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 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.	0 900		

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0 900	Continued From page 49 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute a written contract with the required content for one of one resident (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included type II diabetes without complications, depression and hypertension. R2's service plan, print date June 14, 2022, indicated R2 received services to include, medication administration, dressing, grooming, mobility assist, transfers, bowel/bladder monitoring, housekeeping, and laundry services. On June 15, 2022, at approximately 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's scheduled morning medications. R2's records lacked a written contract to include all of the terms concerning the provisions of the following as required: (1) housing (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and	0 900		

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0 900	Continued From page 50 (3) the resident's service plan, if applicable. In addition, R2's records lacked evidence that the contract had been fully executed as the facility must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and - 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. On June 16, 2022, at approximately 10:00 a.m., licensed assisted living director (LALD)-A provided a compiled set of documents titled; Payment Policy, Client Service Agreement, Rental Agreement, Attachment A, Addendum 1 and Sign-off Sheet for Information Provided. LALD-A confirmed the package of documents were considered by LALD-A to be the written contract. The compiled package of documents did not meet assisted living contract requirements. LALD-A stated, "I had no idea so much needed to be done." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:	0 910		

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0 910	Continued From page 51 (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1,R3, R4) 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: The licensee lacked a written contract with the following required content: - the licensee of the facility; - the managing agent of the facility; and - license number. R1, R3 and R4's Client Service Agreement dated November 5, 2019, October 30, 2021, and June 16, 2021, respectively, indicated the licensee held an Assisted Living license, however, lacked requirements noted above. On June 16, 2022, at approximately 10:00 a.m., licensed assisted living director (LALD)-A provided a compiled set of documents titled;	0 910		

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0 910	Continued From page 52 Payment Policy, Client Service Agreement, Rental Agreement, Attachment A, Addendum 1 and Sign-off Sheet for Information Provided. LALD-A confirmed the package of documents were considered by LALD-A to be the assisted living written contract. The compiled package of documents did not meet assisted living contract requirements. Additionally, a blank assisted living contract set of documents, similar to the provided signed documents, referred to as the assisted living contract, were provided to the surveyor but had not been implemented. LALD-A stated, "I had no idea so much needed to be done." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract;	0 920		

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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
0 920	Continued From page 53 (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R1, R3, R4) 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, R3 and R4's contracts lacked the following: - disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; - a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; - a delineation of the cost and nature of any other services to be provided for an additional fee;	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30400	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR BROOK VILLA	20868 SUGAR HILLS ROAD COHASSET, MN 55721

(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
0 920	Continued From page 54 - a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; - a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; and - disclosure of the facility's ability to provide specialized diets. R1, R3 and R4's Client Service Agreement dated November 5, 2019, October 30, 2021, and June 16, 2021, respectively, indicated a payment policy was in place, however, lacked the requirements noted above and referenced comprehensive licensing throughout the documents. On June 16, 2022, at approximately 10:00 a.m., licensed assisted living director (LALD)-A provided a compiled set of documents titled; Payment Policy, Client Service Agreement, Rental Agreement, Attachment A, Addendum 1 and Sign-off Sheet for Information Provided. LALD-A confirmed the package of documents were considered by LALD-A to be the assisted living written contract. The compiled package of documents did not meet assisted living contract requirements. Additionally, a blank assisted living contract set of documents, similar to the provided signed documents, referred to as the assisted living contract, were provided to the surveyor but had not been implemented. LALD-A stated, "I had no idea so much needed to be done." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 930	Continued From page 55	0 930		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content for three of three residents (R1, R3, R4) 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).	0 930		

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0 930	Continued From page 56 The findings include: R1, R3 and R4's assisted living contracts lacked the following content: - the right under section 144G.54 to appeal the termination of an assisted living contract; - the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; and - contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints. R1 R1's Client Service Agreement dated November 5, 2019, indicated R1 received services including medication administration, oxygen monitoring, compression stockings assistance, bathing, grooming, toileting, ambulation, transfers and dressing. R1's assisted living contract signed November 5, 2019, lacked content listed above. R3 R3's Client Service Agreement dated October 21, 2021, indicated R3 received services for medication administration bathing, treatments as ordered, orientation, grooming, dressing, meals, assistance with leg elevation, laundry and housekeeping. R3's assisted living contract signed October 30, 2021, lacked content listed above.	0 930		

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0 930	Continued From page 57 R4 R4's Assessment dated October 20, 2021, indicated R4 received services for medication administration, bathing, grooming, dressing, bladder/bowel monitoring and vitals monitoring. R4's assisted living contract signed June 16, 2021, lacked content listed above. On June 16, 2022, at approximately 10:00 a.m., licensed assisted living director (LALD)-A provided a compiled set of documents titled; Payment Policy, Client Service Agreement, Rental Agreement, Attachment A, Addendum 1 and Sign-off Sheet for Information Provided. LALD-A confirmed the package of documents were considered by LALD-A to be the assisted living written contract. The compiled package of documents did not meet assisted living contract requirements. Additionally, a blank assisted living contract set of documents, similar to the provided signed documents, referred to as the assisted living contract, were provided to the surveyor but had not been implemented. LALD-A stated, "I had no idea so much needed to be done." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide	0 940		

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0 940	Continued From page 58 customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with all required content for three of three residents (R1, R3, R4) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than	0 940		

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0 940	Continued From page 59 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, R3 and R4's assisted living contracts lacked the following content: -a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: -whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; -whether the facility has agreement to provide housing support under section 256I.04 subd. 2, paragraph (b) - statement the MA waivers provide payment for services but do not cover the cost of rent; -statement that residents may be eligible for assistance with rent through the housing support program; and -description of the rent requirements for people who are eligible for MA waivers but who are not eligible for assistance through housing support program. R1 R1's Client Service Agreement dated November 5, 2019, indicated R1 received services including medication administration, oxygen monitoring, compression stockings assistance, bathing, grooming, toileting, ambulation, transfers and dressing.	0 940		

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0 940	Continued From page 60 R1's assisted living contract signed November 5, 2019, lacked content listed above. R3 R3's Client Service Agreement dated October 21, 2021, indicated R3 received services for medication administration bathing, treatments as ordered, orientation, grooming, dressing, meals, assistance with leg elevation, laundry and housekeeping. R3's assisted living contract signed October 30, 2021, lacked content listed above. R4 R4's Assessment dated October 20, 2021, indicated R4 received services for medication administration, bathing, grooming, dressing, bladder/bowel monitoring and vitals monitoring. R4's assisted living contract signed June 16, 2021, lacked content listed above. On June 16, 2022, at approximately 10:00 a.m., licensed assisted living director (LALD)-A provided a compiled set of documents titled; Payment Policy, Client Service Agreement, Rental Agreement, Attachment A, Addendum 1 and Sign-off Sheet for Information Provided. LALD-A confirmed the package of documents were considered by LALD-A to be the assisted living written contract. The compiled package of documents did not meet assisted living contract requirements. Additionally, a blank assisted living contract set of documents, similar to the provided signed documents, referred to as the assisted living contract, were provided to the surveyor but had not been implemented. LALD-A stated, "I had no idea so much needed to be done."	0 940		

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0 940	Continued From page 61 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
01360 SS=F	144G.61 Subdivision 1 Instructor and competency evaluation requirem Instructors and competency evaluators must meet the following requirements: (1) training and competency evaluations of unlicensed personnel who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be conducted by individuals with work experience and training in providing these services; and (2) training and competency evaluations of unlicensed personnel providing assisted living services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse. 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 were completed as required prior to providing direct care, for one of two unlicensed personnel (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) 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).	01360		

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01360	Continued From page 62 The findings include: ULP-D's employee record lacked evidence of demonstrated competency in all the required topics. ULP-D was hired on July 6, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On June 15, 2022, at 8:26 a.m., the surveyor observed ULP-D administer R1's morning medications. ULP-D's employee record lacked evidence ULP-D had demonstrated competency to a registered nurse (RN) in the following areas: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - 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; - dressing and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating;	01360		

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01360	Continued From page 63 - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and the family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On June 15, 2022, at 10:36 a.m., CNS-B stated, "I was told I don't need to do them [staff training and competencies]. I was told the LPN would do all that. No, I don't do it." Additionally, LPN-C confirmed the previous LPN and LPN-C had signed off staff training and competencies, and stated, "I talk to them [staff] and give a scenario and ask what they [staff] would do in this scenario." On June 16, 2022, at approximately, 10:29 a.m., licensed assisted living director (LALD)-A confirmed ULP-D had not been competency tested by the registered nurse and stated, "the licensed practical nurse (LPN)-C is signing off staff competencies, as you saw." The licensee's 3.06 Delegated vs. Non-nursing Services policy, dated January 2014, indicated licensee would delegate services based on the scope of delegated services and would be determined by the type of Minnesota Home Care license, the Minnesota Nurse Practice Act, accepted medical and nursing standards of practice, and the policies and procedures of licensee. Additionally, the policy indicated	01360		

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01360	Continued From page 64 licensee would verify that staff training, and proof of competency records were accurate and on file. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01360		
01410 SS=F	144G.62 Subd. 2 Delegation of assisted living services (a) A registered nurse or licensed health professional may delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota practice act. The assisted living facility must establish and implement a system to communicate up-to-date information to the registered nurse or licensed health professional regarding the current available staff and their competency so the registered nurse or licensed health professional has sufficient information to determine the appropriateness of delegating tasks to meet individual resident needs and preferences. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and implement a system to communicate up-to-date information to the registered nurse (RN) regarding the current available staff and their competency. The licensed practical nurse (LPN) conducted all staff training and delegation of tasks. Therefore, the RN failed to determine the appropriateness of delegating tasks to meet resident needs and preferences. This affected all 11 residents	01410		

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01410	Continued From page 65 receiving services under the assisted living license. 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 June 14, 2022, at 10:20 a.m., licensed assisted living director (LALD)-A stated the facility employed clinical nurse supervisor (CNS)-B to provide supervision and delegation to staff and conduct resident assessments. LALD-A stated CNS-B had been hired to provide between "1 and 15 hours every two weeks. She wasn't trained, I'll admit that." During record review on June 14, 2022, at approximately 1:00 p.m., the surveyor observed CNS-B's name was not on the staff schedule, not scheduled hours or shifts on the staff schedule and was not on the on-call nursing rotation schedule. The on-call nurse schedule included LPN-C and LALD-A only. No information on either schedule for who the registered nurse was, or how to reach CNS-B. LALD-A stated, "she [CNS-B] is not on the schedule because I don't know when she is ever coming in." During an interview on June 15, 2022, with CNS-B, at approximately 10:30 a.m., CNS-B confirmed she was hired for 1 - 15 hours every 2 weeks and stated her job duties included to	01410		

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01410	Continued From page 66	01410		

complete resident assessments on admission, 14-days and 90-days. CNS-B stated LPN-C would assign the tasks for unlicensed personnel, conduct training and competency tests and conduct day-to-day medical/nursing tasks. CNS-B stated scheduling and policy development was not one of her duties and those tasks were completed by LALD-A. Additionally, CNS-B stated, "I have four other jobs."

On June 15, 2022, at approximately 10:00 a.m., the surveyor interviewed LPN-C and confirmed LPN-C would enter delegated tasks into the computer for staff to complete for each resident. LPN-C stated in regard to the on-call schedule, "staff would send a text to me if something came up or call for direction. They call me all the time." LPN-C stated she would notify CNS-B if "it was something major." LPN-C stated items that were completed and needing to be reviewed by CNS-B were placed into a folder for CNS-B to review and sign when she [CNS-B] was in the building.

On June 16, 2022, at approximately 10:29 a.m., LALD-A stated, "she [CNS-B] came in blind because my other RN quit without notice. She is included in group texts, so she is aware of things. She's definitely not here enough. She wouldn't know the first thing about taking care of [R1] in room [number]."

An RN Supervisor job description dated and signed by CNS-B on June 14, 2021, indicated CNS-B would ensure that the healthcare needs of all residents were met. The RN would ensure that staff were trained in procedures and policies which were current and up to date. Additionally, the job description indicated the RN would ensure that the home care was in compliance with current Comprehensive Home Care regulation

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01410	Continued From page 67 [outdated licensure requirements]. No further information provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01410		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for two of two employees (clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-C) 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 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).	01460		

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	30400	A. BUILDING: _____ B. WING _____	06/16/2022

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01460	Continued From page 68 The findings include: CNS-B CNS-B's employee records did not contain documentation that assisted living orientation training requirements were completed. CNS-B began employment on June 14, 2021, under the comprehensive home care license and began providing direct care and supervisory services under the assisted living services license on August 1, 2021. LPN-C LPN-C's employee records did not contain documentation that assisted living orientation training requirements were completed. LPN-C began employment on April 11, 2022, to provide direct care and supervisory services under the assisted living services license. On June 16, 2022, at approximately 10:30 a.m., licensed assisted living director (LALD)-A confirmed CNS-B and LPN-C's records did not contain documentation that assisted living orientation 144G requirements were completed. Additionally, CNS-B stated, "I came in and interviewed one day and started the next day with no training." LPN-C stated, "same here." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01470 SS=E	144G.63 Subd. 2 Content of required orientation	01470		

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01470	Continued From page 69 (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 training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must	01470		

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01470	Continued From page 70 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 144G licensing requirements for two of two employees (unlicensed personnel (ULP)-E 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, 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-E ULP-E was hired on November 1, 2005, under	01470		

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01470	Continued From page 71 the comprehensive home care license and began providing assisted living services on August 1, 2021. On June 15, 2022, at 8:00 a.m., the surveyor observed ULP-E reposition and provide grooming assistance to R2. ULP-D ULP-D was hired on July 6, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On June 15, 2022, at 8:26 a.m., the surveyor observed ULP-D administer R1's morning medications. ULP-E and ULP-D's records lacked the following required orientation content: - an overview of this chapter; - an introduction and review of the facilities policies and procedures related to the provision of assisted living services by the individual staff person; - 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. On June 16, 2022, at approximately 10:29 a.m., licensed assisted living director (LALD)-A confirmed ULP-E and ULP-D had not completed the assisted living orientation training requirements for 144G as noted above.	01470		

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01470	Continued From page 72 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff received dementia training as required for two of two employees (clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-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), 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: CNS-B CNS-B's employee records did not contain documentation that any dementia training requirements were completed. CNS-B began employment on June 14, 2021, under the comprehensive home care license and	01490		

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01490	Continued From page 73 began providing direct care and supervisory services under the assisted living services license on August 1, 2021. LPN-C LPN-C's employee records did not contain documentation that any dementia training requirements were completed. LPN-C began employment on April 11, 2022, to provide direct care and supervisory services under the assisted living services license. On June 16, 2022, at approximately 10:30 a.m., licensed assisted living director (LALD)-A confirmed CNS-B and LPN-C's records did not contain documentation that any dementia training requirements were completed. Additionally, CNS-B stated, "I came in and interviewed one day and started the next day with no training." LPN-C stated, "same here." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01490		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on	01610		

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01610	Continued From page 74 which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a prescreen initial nursing assessment of the physical and cognitive needs of a prospective 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 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: R6 R6 had a secured move in date of June 18, 2022. R6's diagnoses included arthritis and scoliosis (a condition characterized by sideways curvature of the spine or back bone). R6 had not signed a service plan or assisted living contract as of June 14, 2022.	01610		

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01610	Continued From page 75 R6's record included a document titled Prescreening of Potential Client Needs intended as the initial assessment dated and signed May 30, 2022, by licensed practical nurse (LPN)-C. On June 15, 2022, at approximately 10:29 a.m., licensed assisted living director (LALD)-A confirmed R6 had a confirmed move in date of June 18, 2022, and LPN-C conducted R6's face-to-face initial assessment. A physical and cognitive assessment by a registered nurse (RN) had not been completed for R6. Additionally, LALD-A stated, "we know she [LPN] can't do that now." The licensee's 4.03 assessments - schedules policy dated January 2014, indicated nurses would conduct assessments, monitoring and reassessments consistent with Comprehensive Home Care requirements [outdated licensure requirements]. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring	01650		

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01650	Continued From page 76 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 the service plan included all required content for three of three residents (R2, R1, 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 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:	01650		

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01650	Continued From page 77 R2 R2's diagnoses included type II diabetes. R2's service plan dated January 1, 2022, indicated R2 received services which included medication administration, meals, assistance with activities of daily living, housekeeping and laundry services. On June 15, 2022, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-E reposition and provide grooming assistance to R2. R1 R1's diagnoses included heart failure. R1's service plan dated November 5, 2019, indicated R1 received services including medication administration, oxygen monitoring, compression stockings assistance, bathing, grooming, toileting, ambulation, transfers and dressing. On June 15, 2022, at 8:26 a.m., the surveyor observed ULP-D administer R1's morning medications. R3 R3's diagnoses included frontal dementia. R3's Service Plan dated October 21, 2021, indicated R3 received services for medication administration bathing, treatments as ordered, orientation, grooming, dressing, meals, assistance with leg elevation, laundry and housekeeping. On June 15, 2022, at 8:45 a.m., the surveyor	01650		

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01650	Continued From page 78 observed ULP-D administer R3's morning medications. R2, R1 and R3's service plans lacked the following required content: - a description of the services to be provided, and the frequency of each service, according to the resident's current assessment and resident preferences; - the identification of staff or categories of staff who will provide the services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided; - 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. On June 16, 2022, at approximately 10:29 a.m., licensed assisted living director (LALD)-A confirmed the service plans for R2, R1 and R3 did not contain all requirements for managing and monitoring individual needs. Additionally, LALD-A stated "I probably don't have all the pieces, there are probably things that are missing in them. That stuff is all supposed to be in there, but it isn't." The licensee's 4.09 Service Plans policy dated May 1, 2017, indicated the above referenced requirements would be included in resident service plans and that a service plan would be provided to residents following an assessment completed by a registered nurse (RN) and any change to a service plan would be signed by the	01650		

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01650	Continued From page 79 RN. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall	01690		

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01690	Continued From page 80 management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current medication management policies were developed, implemented, and maintained under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines, 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 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 June 16, 2022, at 10:45 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided medication management services to the licensee's residents. The licensee lacked the following required policies: - requesting and receiving prescriptions for medications; - preparing and giving medications; - verifying that prescription drugs are administered as prescribed; - documenting medication management activities;	01690		

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01690	Continued From page 81 - controlling and storing medications; - monitoring and evaluating medication use; - communicating with the prescriber, pharmacist, and resident and legal and designated representatives; and - disposing of unused medications and educating residents and legal and designated representatives about medications. On June 15, 2022, at 1:10 p.m., clinical nurse supervisor (CNS)-B confirmed the licensee lacked the development and implementation of the above noted policies. However, CNS-B added licensed assisted living director (LALD)-A had just provided her [CNS-B] a thumb drive and policy book that had been received at some time during the last 6 months by a providers group, after assisted living regulation was implemented on August 1, 2021, that CNS-B was unaware the facility had in possession. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01690		
01730 SS=F	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	01730		

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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
01730	Continued From page 82 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 changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for three of three residents (R2, R1, R3) with records reviewed.	01730		

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SUGAR BROOK VILLA	20868 SUGAR HILLS ROAD COHASSET, MN 55721

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01730	Continued From page 83 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 June 14, 2022, at approximately 10:50 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided medication management services to the residents in the facility. R2 R2's diagnoses included type II diabetes. R2's service plan dated January 1, 2022, indicated R2 received services which included medication administration. R2's electronic medical administration record (EMAR) dated June 2022, included one insulin, one antidepressant, one blood thinner, one nerve pain reducer, one blood pressure reducer, two eye drops, one anti-inflammatory, one prostate maintainer, one heart rate stabilizer and one mild pain reliever. On June 15, 2022, at 8:05 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's morning medications. R1 R1's diagnoses included heart failure. R1's service plan dated November 5, 2019,	01730		

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01730	Continued From page 84 indicated R1 received services including medication administration. R1's EMAR dated June 2022, included one cholesterol reducer, six vitamin supplements, one prostate maintainer, one heart rate stabilizer, one nerve pain reducer and one stomach acid reducer. On June 15, 2022, at 8:26 a.m., the surveyor observed ULP-D administer R1's morning medications. R3 R3's diagnoses included frontotemporal dementia. R3's Service Plan date of October 21, 2021, indicated R3 received services for medication administration. R3's EMAR dated June 2022, included two memory enhancers, two vitamin supplement, one antianxiety, one mood stabilizer, one narcotic pain medication and one nerve pain reducer. On June 15, 2022, at 8:45 a.m., the surveyor observed ULP-D administer R3's morning medications. R2, R1 and R3's medication management record did not 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 direction; - documentation of specific resident instructions relating to the administration of medications;	01730		

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01730	Continued From page 85 - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - 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; - 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 reaction; and - completion of medication reconciliation. On June 15, 2022, at approximately 11:28 a.m., clinical nurse supervisor (CNS)-B confirmed R2, R1 and R3's individualized medication management record lacked all required content noted above and stated, "no, I've never seen any of them." CNS-B was referencing individual medication management plans. Licensed practical nurse (LPN)-C confirmed CNS-B's statement and stated, "I don't know what that is either." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=I	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:	01750		

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01750	Continued From page 86 (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 the nursing task of medication administration, 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 for one of two employees (ULP-D) with records reviewed. This resulted in an immediate order issued on July 14, 2022. In addition, the licensee failed to ensure the registered nurse (RN) instructed the ULP in the proper methods to administer medications for two of three residents (R1, R3) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: COMPETENCY OF UNLICENSED PERSONNEL	01750	On July 19, 2022, the immediacy of correction order 1750 was removed, however, non-compliance remained at a level 3, widespread violation.	

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01750	Continued From page 87 ULP-D's employee record lacked evidence ULP-D demonstrated competency to the RN for medication administration. ULP-D ULP-D was hired on July 6, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On June 15, 2022, at 8:26 a.m., the surveyor observed ULP-D administer R1's morning medications. ULP-D stated training was provided by "the nurses" and LALD-A. The surveyor asked who ULP was referring to and, ULP-D stated, "[previously employed LPN]." R1's Electronic Medication Administration Record (EMAR) for June 1- 14, 2022, indicated ULP-D administered medications to R1 on June 1, 2, 3, 6, 7, 8, 9, 11, 12, 13 and 14, 2022. On June 15, 2022, at 10:36 a.m., the surveyor interviewed and asked clinical nurse supervisor (CNS)-B who was responsible for conducting staff training and competencies, including medications. CNS-B stated, "I was told I don't need to do them. I was told the LPN would do all that. No, I don't do it." On June 16, 2022, at approximately 10:29 a.m., licensed assisted living director (LALD)-A confirmed ULP-D's employee record indicated ULP-D had been trained and competency tested by the prior licensed practical nurse (LPN) and lacked documentation of medication administration competency by a registered nurse (RN) as required.	01750		

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01750	Continued From page 88 The licensee's 3.06 Delegated vs. Non-nursing Services policy, dated January 2014, indicated licensee would delegate services based on the scope of delegated services and would be determined by the type of Minnesota Home Care license, the Minnesota Nurse Practice Act, accepted medical and nursing standards of practice, and the policies and procedures of licensee. Additionally, the policy indicated licensee would verify that staff training, and proof of competency records were accurate and on file. INSTRUCTION TO UNLICENSED PERSONNEL R1 R1's diagnoses included heart failure, chronic kidney disease and gastric ulcers. R1's service plan dated November 5, 2019, indicated R1 received services including medication administration. On June 15, 2022, at approximately 8:26 a.m., the surveyor observed ULP-D administer R1's morning medications. ULP-D opened the med caddie (a multicompartment pill storage container) labeled Wednesday morning, poured the medications into a paper medication cup, and counted the number of pills. ULP-D confirmed six pills were in the medication cup and verified all six medications plus one inhaler in the EMAR. All medications listed on the EMAR for R1 lacked pill identifiers for verification. The surveyor asked ULP-D how they verify the medication removed from the med caddie with no pill description. ULP-D stated, "I count the pills listed on the EMAR, count the pills I pour out of the med caddie and with the inhaler that makes seven." R1's EMAR dated June 2022, included the	01750		

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01750	Continued From page 89 following medications: - atorvastatin calcium 80 milligrams (mg) daily; - ferrouSul 325 mg daily; - magnesium oxide 420 mg daily; - prenatal vitamin daily; - vitamin B12 daily; no dose provided - Spiriva Respimat 2.5 microgram (mcg) one inhale daily; - tamsulosin 0.4 mg daily; - vitamin C daily; no dose provided - vitamin D3 daily; no dose provided - gabapentin 300 mg twice daily; - metoprolol tartrate 12.5 mg twice daily; and - pantoprazole sodium 40 mg twice daily. R3 R3's diagnosis included frontotemporal dementia. R3's service plan date of October 21, 2021, indicated R3 received services for medication administration. On June 15, 2022, at approximately 8:45 a.m., the surveyor observed ULP-D administer R3's morning medications. ULP-D removed the foil backed bubble pack from a locked medication cart and verified each medication listed on the EMAR as the medication was popped out through the foiled backing of the medication card. ULP-D verified the pills removed from the bubble pack against the EMAR with the use of pharmacy provided prescription labels attached to the inside cover of the bubble pack. The pharmacy label contained a description of each pill. The surveyor observed a green translucent gel capsule that had been added to the bubble pack card that was not included in the prescription labels or pill information. The inside cover of the bubble pack had a handwritten "vitamin D3 1.25 mg" on the opposite inside cover. The surveyor asked ULP-D	01750		

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01750	Continued From page 90	01750		

what the handwriting on the bubble pack meant. ULP-D stated, "that's her [R3's] vitamin D that she gets. The nurse adds it to the bubble pack so that we give it every Monday." The surveyor observed the back foil of R3's medication bubble pack and observed that every Monday on the bubble pack had been slit open on the card, a green translucent gel capsule had been added to the previously sealed pharmacy bubble pack and was closed back up with scotch tape over the slit.

R3's EMAR dated June 2022, included the following medications:
- vitamin-B complex daily; no dose provided
- duloxetine delayed release 30 mg daily;
- mirtazapine 15 mg daily;
- Seroquel 12.5 mg daily;
- trazadone 50 mg daily;
- vitamin D3 1.25 mg (50,000 units) every Monday;
- memantine 10 mg twice daily; and
- gabapentin 100 mg three times daily.

On June 15, 2022, at approximately 10:00 a.m., LPN-C confirmed staff verified medications from the medication caddies by counting the number of pills poured into a medication cup against the medications listed on the EMAR. LPN-C stated, "yes, I set up med caddies weekly and add the vitamin D3 to [R3's] bubble packs because the family brings in a bottle. That's how it's always been, you want a description in the EMAR? Staff just know when they count the pills."

The licensee's Medication Administration policy dated November 2014, indicated medications provided to residents would be set up in bubble packs provided by a pharmacy and staff would verify the correct day of the week, correct med, correct dosage, correct time and correct resident

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01750	Continued From page 91 and all specific data pertinent to the medication administration and staff should reference the specific resident medication profile, as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the license failed to ensure documentation of medication setup was completed at the time of setup and included all the required content for one of two residents (R1) 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: During the entrance conference on June 14,	01770		

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01770	Continued From page 92 2022, at approximately 10:45 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided medication management services to include medication setup. CNS-B stated the licensed practical nurse (LPN)-C sets up medications for some residents into medication caddies (a medication storage container that is divided into compartments organized by the days of the week and times of the day). R1's diagnoses included heart failure, chronic kidney disease and gastric ulcers. R1's service plan dated November 5, 2019, indicated R1 received services including medication administration. On June 16, 2022, at approximately 9:30 a.m., the surveyor observed LPN-C set up R1's medication caddie. R1's EMAR dated June 2022, included the following medications: - atorvastatin calcium 80 milligrams (mg) daily; - ferrouSul 325 mg daily; - magnesium oxide 420 mg daily; - prenatal vitamin daily; - vitamin B12 daily; no dose provided - Spiriva Respimat 2.5 microgram (mcg) one inhale daily; - tamsulosin 0.4 mg daily; - vitamin C daily; no dose provided - vitamin D3 daily; no dose provided - gabapentin 300 mg twice daily; - metoprolol tartrate 12.5 mg twice daily; and - pantoprazole sodium 40 mg twice daily. On June 16, 2022, at 9:30 a.m., LPN-C stated she setup medication caddies every week for R1. LPN-C provided the surveyor with nursing	01770		

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01770	Continued From page 93 progress notes dated January 9, 2022, through June 13, 2022, (one page). The nursing progress notes were reviewed and contained one nursing note pertaining to medication set up dated June 13, 2022. The nursing documentation stated, "Late Entry: medication set up by LPN." LPN-C confirmed notes are not always entered and/or are entered late at times and did not contain any required information for medication setup. LPN-C stated, "I didn't know I had to do that." R1's records lacked documentation for medication setup at the time of setup to include the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure prescription medications were stored in a secured manner allowing only authorized personnel access. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01880		

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01880	Continued From page 94 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 14, 2022, at approximately 11:15 a.m., in the presence of clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-C, the surveyor observed a medication refrigerator sitting inside the employee/kitchen pantry storage room with the door propped wide open. The medication refrigerator lacked a lock to secure medications. The medication refrigerator contained a full box supply (5 insulin pens) and a single insulin pen belonging to R2 as follows: - one unopened box of 5 Basaglar KwikPens 100 units (u)/milliliter (ml); and - one single Basaglar KwikPen 100 u/ml. On June 14, 2022, at approximately 11:30 a.m., CNS-B and LPN-C confirmed the medication refrigerator contained unsecured medication and was kept in a common area accessible to all staff, residents and visitors. The licensee's policy Central Storage of Medications, undated, indicated all medications were to be kept in a locked storage cabinet in central storage, unless the medication needed refrigeration. Refrigerated medications were to be kept in the small refrigerator in the kitchen pantry. No further information was provided.	01880		

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01880	Continued From page 95 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescription medications were maintained bearing an original prescription label and dated when opened for time sensitive medications for two of three residents (R2, R1) with medications 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: R2 and R1's time-sensitive medications lacked labels and open dates.	01890		

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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
01890	Continued From page 96 R2 On June 15, 2022, at approximately 7:50 a.m., the surveyor observed R2's insulin medications stored in an unrefrigerated medication cart. The surveyor and unlicensed personnel (ULP)-D identified one Basaglar Kwikpen 100 unit/milliliter (ml) insulin pen as R2's. The pen had a worn illegible label that had been blacked out with a marker and had written in its place "order change." The pen did not indicate when it had been opened or taken out of the refrigerator. Basaglar manufacturer's instruction directs to discard the unrefrigerated medication after 28 days. On June 15, 2022, at 7:50 a.m., ULP-D verified R2's insulin pen located in the unrefrigerated medication cart was not labeled and did not have an open date on the pen. R1 On June 15, 2022, at approximately 8:26 a.m., the surveyor observed ULP-D assist R1 with administration of R1's Spiriva Respimat aerosol inhaler. R1's Spiriva Respimat aerosol inhaler 2.5 microgram (MCG)/ actuation (ACT) lacked labels to indicate the date removed from the pouch and opened by staff and when the inhalers would expire. Manufacturer recommendations dated November 2021, indicated the Spiriva Respimat inhaler should be discarded at the latest 3 months after first use or when the locking mechanism is engaged, whichever comes first. On June 15, 2022, at 8:26 a.m., ULP-D verified	01890		

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	30400	A. BUILDING: _____ B. WING _____	06/16/2022

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01890	Continued From page 97 R1's aerosol inhaler was not labeled and did not have an open date on the inhaler. On June 15, 2022, at approximately 10:00 a.m., licensed practical nurse (LPN)-C confirmed the lack of labels and dates for R2 and R1's medications and stated, "yes, the person that opens the item should be writing the date opened. I'm assuming the nurse before me has taught them that." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber	01930		

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01930	Continued From page 98 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines, 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) 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 June 14, 2022, at approximately 11:00 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided treatment and therapy services to residents as prescribed. On June 15, 2022, at approximately 12:20 p.m., the licensee's assisted living licensing policies and procedures were requested from CNS-B. The policies and procedures provided did not include treatment and therapy policies to address the following: - providing the treatment or therapy; - documenting treatment or therapy activities; - educating and communicating with residents about treatments or therapies they are receiving; - monitoring and evaluating the treatment or therapy; and	01930		

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01930	Continued From page 99 - communicating with the prescriber. On June 15, 2022, at approximately 1:10 p.m., CNS-B confirmed the above noted treatment and therapy management services policies and procedures had not been developed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01930		
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	01940		

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01940	Continued From page 100 therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop individual treatment management plans with all required content for one of two residents (R2) who received ordered treatments. 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 June 14, 2022, at approximately 10:45 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B confirmed the licensee provided treatment and therapy services to residents. R2 R2's diagnoses included type II diabetes and hypertension. R2's service plan dated January 1, 2022, indicated R2 received services which included	01940		

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01940	Continued From page 101 medication administration, meals, grooming, dressing, housekeeping and laundry services. On June 15, 2022, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-D obtain a blood (sugar) check for R2 with results of 171 milligrams per deciliter (mg/dl). R2's record lacked an Individualized Treatment and Therapy plan to include the following: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatment 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 the treatments or therapy services; and -any resident-specific requirements related to documentation of treatment and therapy was received, verification all treatment and therapy was administered as prescribed, and monitoring occurred to prevent possible complications or adverse reactions. On June 15, 2022, at approximately 11:28 a.m., clinical nurse supervisor (CNS)-B stated with licensed practical nurse (LPN)-C present, "no, I've never seen any of them." CNS-B was referring to the request by the surveyor for individual treatment and therapy plan for R2. On June 16, 2022, at approximately 10:29 a.m., licensed assisted living director (LALD)-A confirmed R2 lacked an individual treatment and therapy plan and stated, "all that stuff, those things were supposed to be included with the	01940		

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01940	Continued From page 102 assessments. It's not there in the current assessments." The licensee's Treatment/Therapy Management Policy, undated, indicated the registered nurse (RN) would be responsible for development, implementation and maintaining a written treatment or therapy management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	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.	01950		

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01950	Continued From page 103 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) trained and verified competency with treatments and therapies for two of two (unlicensed personnel (ULP)-D and ULP-E) 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) 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-D ULP-D was hired on July 6, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On June 15, 2022, at 7:50 a.m., the surveyor observed ULP-D obtain a blood (sugar) check for R2 with results of 171 milligrams per deciliter (mg/dl). ULP-D's employee record lacked documentation ULP-D was trained and demonstrated competency to a RN to perform blood (sugar) checks. ULP-E ULP-E was hired on November 1, 2005, under the comprehensive home care license and began providing assisted living services on August 1,	01950		

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01950	Continued From page 104 2021. R2's electronic medication administration record (EMAR) dated June 2022, indicated ULP-E had conducted blood (sugar) checks for R2 on the following dates and times: - 8:00 a.m., 11, 12, 2022. ULP-E's employee record lacked documentation ULP-E was trained and demonstrated competency to a RN to perform blood (sugar) checks. On June 16, 2022, at approximately 10:29 a.m., licensed assisted living director (LALD)-A confirmed ULP-D and ULP-E's personnel file did not contain documentation the ULP's had been trained or deemed competent by the RN to provide blood (sugar) checks to R1 or R2. ULP-D and ULP-E's personnel file indicated all training and competency was completed by licensee's previously employed licensed practical nurse (LPN) and signed off with LALD-A. LALD-A stated, "the LPN is signing off competencies, as you saw." The licensee's Treatment/Therapy Management Policy, undated, indicated the registered nurse (RN) would be responsible for development, implementation and maintaining a written treatment or therapy management plan and ULP's would be trained and demonstrate competencies for all treatments and therapies to the licensed nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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02240	Continued From page 105	02240		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate	02240		

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02240	Continued From page 106 because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the residents and a written acknowledgement received for three of three residents (R1, R2, 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: The licensee was licensed as an Assisted Living facility on August 1, 2021, with a bed capacity of 12 residents. R1 R1's diagnoses included heart failure, chronic kidney disease and gastric ulcers. R1's record included an acknowledgement dated November 5, 2019, that the resident had received the Minnesota Home Care Bill of Rights.	02240		

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02240	Continued From page 107 R2 R2's diagnoses included type II diabetes and hypertension. R2's record included an acknowledgement dated January 1, 2022, that the resident had received the Assisted Living Home Care Bill of Rights. R3 R3's diagnosis included frontal dementia. R3's record included an acknowledgement dated October 30, 2021, that the resident had received the Minnesota Home Care Bill of Rights. On June 16, 2022, at approximately 10:29 a.m., licensed assisted living director (LALD)-A confirmed the Minnesota Home Care Bill of Rights acknowledgements were in resident records and stated she was in the process of attaining signatures from the residents or their representatives for the updated Minnesota Bill of Rights for Assisted Living Residents. LALD-A stated, "I add them into the touring package, then they walk out the door. I need to think further ahead on that one." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
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	03090		

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03090	Continued From page 108 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 and interview, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 14, 2022, at approximately 11:15 a.m., during the tour of the facility, the surveyor observed cameras throughout the facility, but no electronic monitoring notice posted on entry or in the facility with the statutory required language. On June 14, 2022, at approximately 11:30 a.m., licensed assisted living director (LALD)-A acknowledged the licensee failed to post the required electronic monitoring notice. LALD-A stated, "there are seven total, and the monitors are in my office. We will get that posted."	03090		

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03090	Continued From page 109 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

DEPARTMENT OF HEALTH

Type: Full
Date: *06/15/22*
Time: 08:07:44
Report: 1019221051

Food and Beverage Establishment Inspection Report

Location:
Sugar Brook Villa
20868 Sugar Hills Road
Cohasset, MN55721
Itasca County, 31

Establishment Info:
ID #: 0038262
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183265730
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.

3-500B Microbial Control: hot and cold holding
3-501.16A2 ** **Priority 1** **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

REFRIGERATOR IN KITCHEN WAS NOT HOLDING TCS FOODS AT OR UNDER F41 DEGREES F. (DISCARDED ALL LEFTOVER ITEMS INCLUDING MASHED POTATOES, BOILED POTATOES, RIBS, MEATLOAF, AND GREEN BEANS). FRIDGE WAS RESET TO COOL TO 41 F OR LESS.

Corrected on Site

3-800 Highly Susceptible Populations
3-801.11C ** **Priority 1** **

MN Rule 4626.0447C Discontinue serving raw or partially cooked animal foods or sprouts to a highly susceptible population.

ESTABLISHMENT CURRENTLY USES FARM FRESH EGGS TO PREPARE SUNNY SIDE UP/POACHED EGGS FOR RESIDENTS.

Corrected on Site

4-300 Equipment Numbers and Capacities
4-302.14 ** **Priority 2** **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

ESTABLISHMENT DOES NOT HAVE A WAY TO TEST THE BLEACH SANITIZING SOLUTION.

Comply By: 06/16/22

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12AMN

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

ASSISTED LIVING DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER ON STAFF

Comply By: 06/16/22

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

KITCHEN REFRIGERATOR WAS NOT ADJUSTED TO MANUFACTURER'S SPECS.

Comply By: 06/16/22

Surface and Equipment Sanitizers

Chlorine: = 200 PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 44 F Degrees Fahrenheit - Location: KITCHEN FRIDGE - MILK
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 F Degrees Fahrenheit - Location: BACK FRIDGE
Violation Issued: No

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

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

DISCUSSION:
NEW FOOD CODE,
TESTING HOT WATER DISH MACHINE,
TEMP. CHECKING FRIDGE IN KITCHEN,
CFPM LICENSING,

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 inspection report number 1019221051 of 06/15/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____ Signed:_____

Establishment Representative

Jared Morrill
Sanitarian
Bemidji
218 308-2128