November 6, 2023

Licensee
Colleens Caring Hands
2525 Bemidji Avenue North
Bemidji, MN 56601

RE: Project Number(s) SL30648015

Dear Licensee:

On October 26, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 26, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

HHH

Electronically Delivered

September 20, 2023

Licensee
Colleen's Caring Hands
2525 Bemidji Avenue North
Bemidji, MN 56601

RE: Project Number(s) SL30648015

Dear Licensee:

On September 12, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on June 21, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the June 21, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on June 21, 2023, found not corrected at the time of the September 12, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 - $500.00
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f)
0910-Contract Information-144g.50 Subd. 2 (a-B)
0950-Designation Of Representative-144g.50 Subd. 3
1290-Background Studies Required-144g.60 Subdivision 1 - $500.00
1890-Prescription Drugs-144g.71 Subd. 20
2040-Fire Protection And Physical Environment-144g.81 Subdivision 1

The details of the violations noted at the time of this follow-up survey completed on September 12, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on September 12, 2023, we identified the following violation(s):

0110-Assisted Living Director License Required-144g.10 Subdivision 1a - $500.00
0940-Contract Information-144g.50 Subd. 2 (e; 5-7)
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E)

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify

these state correction orders. It is not necessary to develop a plan of correction.

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

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

IMPOSITION OF FINES:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30648	A. BUILDING: _____ B. WING _____	R 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEENS CARING HANDS INC	2525 BEMIDJI AVENUE NORTH BEMIDJI, MN 56601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL30648015-1 On September 11, 2023, through September 12, 2023, 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 21, 2023. At the time of the survey, there were ten residents: all whom were receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued. An immediate correction order was identified on September 11, 2023, at 2:00 p.m., issued for SL30648015-1, tag identification 0110. As of September 12, 2023, at time of exit, the immediacy of correction order 0110 remained, and non-compliance remains at a scope and level of F.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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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0 110	Continued From page 1	0 110		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of an assisted living director (LALD) licensed by the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all residents receiving Assisted Living with Dementia Care services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). This resulted in an immediate correction order identified on September 11, 2023, at 2:00 p.m. The findings include: On September 11, 2023, at 9:36 a.m., during the entrance conference with owner (O)-G and licensed practical nurse (LPN)-B; O-G stated clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A no longer worked at the facility. When asked who the current LALD was for the facility, O-G stated, "that's a good question." O-G stated the plan was for LPN-B to	0 110		

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0 110	Continued From page 2 obtain the LALD certification. LPN-B stated she had not started the process yet to become the LALD for the facility. The BELTSS licensed verification website on September 11, 2023, at 9:40 a.m., indicated CNS/LALD-A had ended her position as the director of record for the facility on August 9, 2023. LPN-B was not listed as having a LALD certification. On September 11, 2023, at 12:35 p.m., LPN- B stated CNS/LALD-A's last date of employment was August 3, 2023. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate As of survey exit on September 12, 2023, at 3:35 p.m., the immediacy of this order had not been removed.	0 110		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;	{0 470}		

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{0 470}	Continued From page 3 (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 and implement a staffing plan to meet the scheduled and reasonably unscheduled needs of the residents. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 11, 2023, at 9:51 a.m., owner (O)-G stated the usual staffing schedule for the facility was as follows:	{0 470}		

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{0 470}	Continued From page 4 - clinical nurse supervisor (CNS)-H was on site during daytime hours for two days a week - licensed practical nurse (LPN)-B was on site Monday through Friday daytime hours - from 7:00 a.m. to 9:00 p.m., Monday through Friday three direct care staff were scheduled - from 7:00 a.m. to 7:00 p.m., Saturday and Sunday three direct care staff were scheduled - from 7:00 p.m. to 9:00 p.m., Saturday and Sunday two direct care staff were scheduled - from 9:00 p.m. to 7:00 a.m., Monday through Sunday one direct care staff was scheduled On September 11, 2023, at 9:57 a.m., O-G stated the facility had two residents who required an assist of two with transfers. R4 used a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability) with assist of two staff members for transferring and R7 required two staff members to assist with transferring during the daytime hours and at night R7 had a commode in her room and one staff member had been able to transfer R7 during the nighttime. R4's service plan dated August 10, 2023, indicated R4 required an assist of two and used a mechanical lift for transfers. On September 12, 2023, at 10:57 a.m., the surveyor observed unlicensed personnel (ULP)-J and ULP-K transfer R4 from her wheelchair to the toilet using a sit to stand lift. R7's service plan dated August 20, 2023, indicated R7 required an assist of two for transfers. The Facility Staffing Plan dated August 29, 2023, indicated the appropriate direct care staffing plan	{0 470}		

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{0 470}	Continued From page 5 for the facility was as follows: - 7:00 a.m. to 3:00 p.m. (three direct care staff) - 3:00 p.m. to 9:00 p.m. (two direct care staff) - 9:00 p.m. to 7:00 a.m. (one direct care staff) The licensee's posted Staffing Schedule dated July 30, 2023, through September 11, 2023, indicated the following: - 7:00 a.m. to 3:00 p.m., three direct care staff - 3:00 p.m. to 9:00 p.m., three direct care staff - 9:00 p.m. to 7:00 a.m., one direct care staff The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated June 26, 2023, indicated the licensee provided "Transfers with assist of two staff". On September 11, 2023, at 1:12 p.m., O-G again stated on the night shift from 9:00 p.m. to 7:00 a.m., there was only one direct care staff scheduled for the facility. O-G stated R4 always required an assist of two for all transfers; however, during the nighttime R7 used a commode and so far, one staff member had been able to transfer R7 during the nighttime hours. O-G stated if another person was needed during the nighttime hours the ULP would call herself or CNS-H. O-G stated she could be at the facility within 10 minutes. The licensee's Staffing Plan dated August 29, 2023, noted staff were responsible for all residents in the building to meet the scheduled and reasonably foreseeable unscheduled needs for residents 24 hours per day. No further information was provided.	{0 470}		

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{0 480}	Continued From page 6	{0 480}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.	{0 680}		

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{0 680}	Continued From page 7 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's undated EPP included a Hazard and Vulnerability Assessment (HVA), and generic instructions for staff to follow in case of a fire, severe weather, tornado, loss of power, bomb, water shortage, winter storm, and evacuation. The licensee's EPP did not include the following: - a quarterly review of the missing resident policy; - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water,	{0 680}		

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{0 680}	Continued From page 8 medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems); - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated; - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - the development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - names and contact information for entities providing services under arrangement, resident physicians, other facilities, volunteers; - arrangement with other facilities; - contact information for tribal, local EP staff, and ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families. - an EP training and testing program On September 12, 2023, at 2:42 p.m., after a	{0 680}		

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{0 680}	Continued From page 9 brief review of the components required in an EPP by the surveyor, owner (O)-G stated the facility's EPP was incomplete. The licensee's undated Emergency Preparedness Plan - Appendix Z Compliance policy noted the intent is the EPP would be aligned with the Centers for Medicare and Medicaid Services State Operations Manual Appendix Z. The EPP will include all the elements of Appendix Z. No further information was provided.	{0 680}		
{0 810} SS=C	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 their own evacuation shall be trained on the	{0 810}		

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{0 810}	Continued From page 10 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 record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings include: A record review of available documentation and interview were conducted on September 6, 2023, at approximately 10:30 a.m. of documents provided by owner (O)-G and licensed practical nurse (LPN)-B on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation	{0 810}		

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{0 810}	Continued From page 11 indicated that the licensee did not have specific employee actions for this facility to be taken in the event of a fire or similar emergency located within the plan. The plan did include some employee actions but needed more site-specific direction. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents located within the plan. Record review of the available documentation indicated the licensee did not have unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Employee training is required to be documented separately from drills. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Record review of the available documentation indicated that evacuation drills had been conducted but not in the required sequence of twice per year per shift and at least once every other month. All deficiencies were verified by O-G and LPN-B during the interview at approximately 11:00 a.m. No further information was provided.	{0 810}		

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{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 health facility identification 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: (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, R2, R5). 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's Resident Contract (assisted living contract) was signed by the resident's representative August 2, 2023. R2's Resident Contract was signed by the resident's representative August 18, 2023.	{0 910}		

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{0 910}	Continued From page 13 R5's Resident Contract was signed by the resident's representative August 3, 2023. R1, R2, and R5's assisted living contracts did not include the provider's identification number (HFID). On September 12, 2023, at 2:13 p.m., owner (O)-G stated the contract was a template contract used by the licensee for all residents. O-G stated the contract did not include the licensee's identification number of the facility. No further information as provided.	{0 910}		
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 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;	0 940		

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0 940	Continued From page 14 (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 ensure the assisted living contract included all required content for three of three residents (R1, R2, R5). This had the potential to affect all ten residents who received assisted living 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: R1 R1's service plan dated August 7, 2023, indicated services included medication administration, oxygen therapy, and assistance with dressing,	0 940		

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0 940	Continued From page 15 grooming, toileting, bathing, housekeeping, and laundry. R2 R2's service plan dated August 13, 2023, indicated services included medication administration, assistance with dressing, grooming, toileting, bathing, housekeeping, and laundry. R5 R5's service plan dated August 3, 2023, indicated R5 received services to include medication administration, assistance with dressing, oral hygiene, grooming, bathing, transferring and toileting. R1, R2, and R5's Resident Contract (assisted living contract) dated August 2, 2023, August 18, 2023, and August 3, 2023, respectively, did not include the following information: - 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; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; and - 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. On September 12, 2023, at 2:17 p.m., owner (O)-G stated the assisted living contract was a template contract used by the licensee for all residents. O-G stated the assisted living contract did not include the above noted content.	0 940		

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0 940	Continued From page 16 No further information was provided.	0 940		
{0 950} SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of three residents'	{0 950}		

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{0 950}	Continued From page 17 (R1, R2, R5) assisted living contract included a notice with the required verbiage for the residents to identify a designated representative. This had the potential to affect all ten residents who received services at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included hypothyroidism (underactive thyroid), hypertension (HTN-high blood pressure), and osteoporosis. R1's service plan dated August 7, 2023, indicated services included medication administration, oxygen therapy, and assistance with dressing, grooming, toileting, bathing, housekeeping, and laundry. R2 R2's diagnoses included dementia, congestive heart failure (condition in which the heart's function as a pump is inadequate to meet the body's needs), depression, and chronic obstructive pulmonary disease (COPD-chronic inflammatory lung disease that causes obstructed airflow from the lungs). R2's service plan dated August 13, 2023, indicated services included medication administration, assistance with dressing,	{0 950}		

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{0 950}	Continued From page 18 grooming, toileting, bathing, housekeeping, and laundry. R5 R5's diagnoses included cognitive impairment, HTN, hyperlipidemia (high cholesterol), and gastroesophageal reflux disease (GERD-stomach acid reflux-heartburn). R5's service plan dated August 3, 2023, indicated R5 received services to include medication administration, assistance with dressing, oral hygiene, grooming, bathing, transferring and toileting. R1, R2, and R5's records did not include evidence of a notice with the required statutory language for the resident to identify a designated representative or documentation R1, R2 and/or R5 declined to name a designated representative. On September 12, 2023, at 2:21 p.m., owner (O)-G stated the revised assisted living contract did not include the include the language required as written in the statute regarding the resident's right to identify a designated representative. No further information was provided.	{0 950}		
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.	{01290}		

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{01290}	Continued From page 19 (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living license for one of two employees (unlicensed personnel (ULP)-I). 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: ULP-I was hired on July 5, 2023, to provide direct care services to the licensee's residents. ULP-I's record lacked documentation of a background study affiliated with the licensee's licensee. On September 12, 2023, at 1:51 p.m., the surveyor reviewed the licensee's Minnesota Department of Human Services NetStudy 2.0 Background Study roster with owner (O)-G and licensed practical nurse (LPN)-B. O-G stated ULP-I was currently an employee of the licensee;	{01290}		

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{01290}	Continued From page 20 however, the background study was not affiliated with the current assisted living license. The licensee's undated Background Study policy indicated the licensee will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors. No further information was provided.	{01290}		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 21 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a comprehensive reassessment for one of one resident (R3) with a change of condition. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3's diagnoses included cognitive impairment with confusion, compression fractures, atrial fibrillation (irregular often fast heartrate), and arthritis. R3's service plan dated January 7, 2021, and revised service plan dated August 17, 2023, indicated R3 received services to include medication management, assistance with transfers, toileting, bathing, dressing, and grooming. R3's Fall Risk Assessments (one undated and one with a review date of August 1, 2023), deemed R3 as a "high" fall risk. R3's Incident Report dated July 12, 2023, and written by unlicensed personnel (ULP)-E indicated R3 had been coming out of the bathroom after a shower. The staff was holding R3's hand walking out and R3 didn't want to hold on to the staff member and the staff member	01620		

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01620	Continued From page 22 turned around and R3 had fallen backwards on her right side. The registered nurse (RN) was called. An ambulance was called and R3 was transported to the hospital. R3's daughter brought R3 back with a sling on and orders for a follow up appointment with "ortho" (orthopedics) the following day. The bottom of the Incident Report was left blank by "RN Signature" and "Date". R3's Progress Notes (PN) dated July 12, 2023, 1:35 p.m., written by ULP-E indicated R3 had a shower after breakfast then when leaving the bathroom came out to kitchen and went to turn around and fell back and landed on her right side. The ambulance was called and R3 was sent to the hospital. PN dated July 12, 2023, 6:35 p.m., written by ULP-I indicated R3 had returned from the hospital and complained a few times that her arm hurt. R3 was given Tylenol to manage the pain. R3's emergency room visit dated July 12, 2023, noted R3 had a contusion of her scalp; facial abrasion, and a closed displaced fracture of the proximal end of the right humerus (a break at the shoulder at the top of the upper arm bone). R3's arm was placed in a sling and R3 was directed to follow up with the orthopedic clinic to discuss further care for the arm fracture. R3's orthopedic provider notes dated July 13, 2023, indicated R3 had a "Proximal humerus fracture". R3's record dated July 12, 2023, through July 30, 2023, lacked a change of condition reassessment following the incident which R3 sustained a fall with a fracture.	01620		

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01620	Continued From page 23 On September 11, 2023, at 2:42 p.m., owner (O)-G stated there were no notes from the previous RN with regards to a reassessment following R3's fall with fracture on July 12, 2023. On September 12, 2023, at 11:52 p.m., clinical nurse supervisor (CNS)-H stated a timely change of condition reassessment should have been completed on R3 following her fall with a fracture and this had not been completed by the previous RN. The licensee's undated Resident Change of Condition or Need policy indicated when changes in condition or need are identified, a RN would initiate a change in condition assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
{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 medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for	{01890}		

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COLLEENS CARING HANDS INC	2525 BEMIDJI AVENUE NORTH BEMIDJI, MN 56601

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{01890}	Continued From page 24 two of three residents (R7, R9). 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 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: On September 11, 2023, at 10:20 a.m., the surveyor reviewed the locked medication cupboard with licensed practical nurse (LPN)-B. LPN-B observed and confirmed the following: R7 R7's open bottle of timolol maleate 0.5% (glaucoma medication) ophthalmic solution did not have a label which indicated the date the eye drop solution had been opened and when the solution would expire. R9 R9's open bottle of timolol maleate 0.5% ophthalmic solution did not have a label which indicated the date the eye drop solution had been opened and when the solution would expire. On September 12, 2023, at 11:50 a.m., clinical nurse supervisor (CNS)-H stated all time sensitive medications should be labeled with a date when opened and a date when they would expire. The manufacturer's instructions for timolol maleate 0.5% ophthalmic solution dated June	{01890}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30648	A. BUILDING: _____ B. WING _____	R 09/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEENS CARING HANDS INC	2525 BEMIDJI AVENUE NORTH BEMIDJI, MN 56601

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{01890}	Continued From page 25 2020, indicated any contents remaining four weeks after opening should be discarded. No further information was provided.	{01890}		
{02040} SS=C	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings include:	{02040}		

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{02040}	Continued From page 26 A record review of available documentation and interview were conducted September 6, 2023, at approximately 10:30 a.m. with licensed practical nurse (LPN)-B and owner (O)-G on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. This deficient condition was verified by LPN-B and O-G during the interview at approximately 11:00 a.m. No further information was provided.	{02040}		

Electronically Delivered

July 3, 2023

Licensee
Colleen's Caring Hands
2525 Bemidji Avenue North
Bemidji, MN 56601

RE: Project Number(s) SL30648015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 21, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

circumstance.

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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.

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues.

The Department of Health staff would like to schedule a conference call with Colleen's Caring Hands to discuss the current ineligibly to renew the Adult Assisted Living Facility with Demential Care licence due to the current state of mixed occupancy. Please contact Jess Schoenecker at 651-201-3789 **on or before July 6, 2023**, to schedule the conference call.

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30648015 On June 20, 2023, through June 21, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were ten active residents; all whom were receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on June 20, 2023, at 4:47 p.m., issued for SL30648015, tag identification 2310. On June 21, 2023, at 3:29 p.m., immediacy of correction order 2310 was removed as confirmed by evaluation supervisor, however, non-compliance remains at a scope and level of F. An immediate correction order was identified on June 21, 2023, at 9:30 a.m., issued for	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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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0 000	Continued From page 1 SL30648015, tag identification 1290. On June 21, 2023, at 4:18 p.m., immediacy of correction order 1290 was removed as confirmed by evaluation supervisor, however, non-compliance remains at a scope and level of G.	0 000		
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)?Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter.? (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e).? (b)?The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.? (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e).? (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.? (e) Upon approving an application for an assisted living facility license, the commissioner may:?	0 100		

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0 100	Continued From page 2 (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or? (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee is not legally responsible for the management, control, and operation of the facility in which the licensee is providing assisted living with dementia care services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 29, 2023, at 9:00 a.m., the surveyor arrived at the licensee's address at 2525 Bemidji Avenue North, Bemidji, Minnesota, 56601, and observed a single level "L" shaped building with six doors opening to the parking lot of the facility. The surveyor observed on the front lawn of the facility a sign, with the writing "Colleen's Caring Hands". Licensed practical nurse (LPN)-B	0 100		

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0 100	Continued From page 3 arrived at the facility at the same time and unlocked and granted the surveyor entry into the facility through an unmarked door. On June 20, 2023, at 10:07 a.m., the surveyor toured the building with LPN-B. The surveyor observed a closed-door with a dead bolt at the end of the assisted living portion of the building, off a small dining room area and in between resident room number 10 and a bathroom. Positioned in front of the door was a commode and taped on the door was a hand-written sign which read "Private Do Not Enter". The surveyor asked LPN-B what was behind the door. LPN-B responded she was unsure what was behind the door. LPN-B proceeded to move the commode, unlocked the dead bolt, and opened the door. Immediately as the door was being opened a voice came from the other side saying, "this is an apartment". LPN-B quickly closed, and dead bolted the door. LPN-B stated she did not know who lived in the apartment and maybe cook (C)-C knew as she had worked at the facility a long time. On June 20, 2023, at 11:37 a.m., cook (C)-C stated there were three apartments in the same building as the assisted living with dementia care facility. C-C stated there were four people (two adults and two teenaged children) who lived in the apartment in which was opened; in the next apartment there was one adult; and then herself and her adult daughter occupied the third apartment. C-C stated owner (O)-G did not own the building, O-G rented the portion of the building in which the assisted living residents resided from a rental management company. C-C stated the management company rented the three apartments to the general public.	0 100		

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0 100	Continued From page 4 A review of the Application for Assisted Living License, signed by O-G on July 27, 2022, indicated on page 1, the physical address of the facility was 2525 Bemidji Avenue North, Bemidji, Minnesota, 56601. The Application further indicated on page 5, with a check mark, the licensee declared was the owner or authorizing agent and attested to reading Minn. Stat. chapter 144G and Minnesota Rules, chapter 4695, governing the provision of assisted living facilities, and understand as the licensee was legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100		
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	0 250		

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0 250	Continued From page 5 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, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (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.	0 250		

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0 250	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 20, 2023, at 9:27 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent RN-A, identified, I certify I have read and understand the following: [a check mark was placed before each of the following]:	0 250		

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0 250	Continued From page 7 - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 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	0 250		

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0 250	Continued From page 8 enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - 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.	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30648	A. BUILDING: _____ B. WING _____	06/21/2023

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0 250	Continued From page 9 Page six was electronically signed by authorizing agent owner (O)-G on July 27, 2022. The licensee had an assisted living with dementia care license reissued on August 1, 2022, with an expiration date of July 31, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - medication management; - treatment management; - supervision of unlicensed personnel (ULP) performing delegated tasks; and - 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. As a result of this survey, the following orders were issued 0100, 0250, 0470, 0480, 0485, 0550, 0630, 0640, 0660, 0680, 0730, 0780, 0790, 0800, 0810, 0910, 0920, 0930, 0940, 0950, 1290, 1440, 1640, 1690, 1710, 1730, 1760, 1830, 1880, 1890, 1940, 1960, 1970, 2040, 2310, 2410, and 3070, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		

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0 470	Continued From page 10	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (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 and implement a staffing plan to determine staffing levels to meet the needs of all residents; and failed to ensure the staffing schedule was posted as required. This had the potential to affect all residents, staff, and visitors.	0 470		

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0 470	Continued From page 11 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license. The facility was licensed for a capacity of ten and had a current census of ten residents. During the entrance conference on June 20, 2023, at 9:58 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the usual staffing schedule for the facility was as follows: - CNS/LALD-A was on site during daytime hours for approximately two hours a week - licensed practical nurse (LPN)-B was on site for approximately 10 hours a week - the day shift was staffed with two to three unlicensed personnel (ULP) from 7:00 a.m. to 7:00 p.m. - the night shift was staffed with one ULP from 7:00 p.m. to 7:00 a.m. On June 20, 2023, at 11:39 a.m., during a tour of the facility with licensed practical nurse (LPN)-B and CNS/LALD-A the surveyor did not observe a posted staff schedule. On June 20, 2023, at 1:28 p.m., CNS/LALD-A stated the schedule was posted in the nursing station area. The surveyor observed on top of a	0 470		

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0 470	Continued From page 12 dorm sized refrigerator a large "At-A-Glance" monthly calendar for June. Written in pencil by each date were the staff names scheduled to work. CNS/LALD-A stated the staff schedule was not prominently posted for residents and visitors to access. On June 21, 2023, at 11:26 a.m., CNS/LALD-A stated a staffing plan for the facility had not been developed. The licensee's undated Staffing and Scheduling policy indicated the CNS would develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. The daily work scheduled must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	0 480		

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0 480	Continued From page 13 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 June 20, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of	0 485		

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0 485	Continued From page 14 similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post a menu a week in advance that was made available to all residents. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 20, 2023, at 11:20 a.m., during a tour of the facility with licensed practical nurse (LPN)-B, the surveyor did not observe a weekly menu posted. On June 21, 2023, at 8:31 a.m., cook (C)-C stated the menu was posted on the inside of one of the cupboards in the kitchen. C-C opened the kitchen cupboard door and taped to the inside of the door was an undated partially completed menu for Monday through Sunday. There were menu items listed for Monday (breakfast, lunch, and supper); Tuesday (breakfast and supper);	0 485		

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0 485	Continued From page 15 Wednesday (breakfast and supper); and Sunday (breakfast, lunch, and supper). All other days/mealtimes were left blank. In addition, the meals on the menu posted were nondescriptive and included "frozen dinner", "pasta", and "soup". C-C stated owner (O)-G usually did the cooking and she was on vacation this week so that was why the menu wasn't completed. The licensee's undated Food Service and Menu Planning policy indicated menus would be prepared at least one (1) week in advance and made available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.	0 550		

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0 550	Continued From page 16 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. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 20, 2023, at 1:42 p.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. The bulletin board by one of the main entrances had the facility's grievance procedure posted; however, the grievance procedure posted did not include the required content to include the contact information for the Office for Mental Health and Developmental Disabilities and the e-mail contact information for owner (O)-G who was listed as the individual responsible for handling resident grievances. CNS/LALD-A stated the above noted information was not posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		

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0 630	Continued From page 17	0 630		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an 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 observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was implemented 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) 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 cognitive impairment with confusion, compression fractures, atrial fibrillation (irregular often fast heartrate), and arthritis. R3's Vulnerability Assessment/Abuse Prevention	0 630		

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0 630	Continued From page 18 Plan dated January 2, 2021, identified wandering/elopement risk as an area of vulnerability with an approach/intervention plan which included a secure environment. R3's Service Plan dated November 18, 2021, indicated R3 received services which included medication administration, assistance with dressing, grooming, toileting, and bathing. R3's assessment dated May 3, 2023, indicated R3 had severe cognitive impairment, was a low risk for elopement, at risk for falls, transferred and ambulated independently. On June 20, 2023, at 11:42 a.m., during a tour of the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A and licensed practical nurse (LPN)-B the surveyor observed across from R3's room an open hallway which led to an exit door. LPN-B stated this exit door was the "employee entrance" and was always unlocked from the inside but locked from the outside, so anyone could exit the building, but couldn't get back in without ringing the doorbell or calling the main number of the facility. CNS/LALD-A stated there was no alarm activated when exiting this door. LPN-B stated this "employee entrance" door opened into the facility's parking lot and just to the left of the facility parking lot was a "busy" road. On June 20, 2023, at 12:18 p.m., the surveyor observed R3 standing in front of an alarmed exit door by the washer and dryer machines. R3 was looking out the exit door window. On June 20, 2023, at 1:12 p.m., CNS/LALD-A stated potentially a resident could get out of the facility through the "employee entrance" door and	0 630		

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0 630	Continued From page 19 would not be able to get back in. CNS/LALD-A stated R3 was independently mobile and R3's room was directly across from the open hallway which led to the unlocked and unalarmed "employee entrance" door. CNS-/LALD-A stated four of the five facility's exit doors do alarm when exited, but not this one. On June 20, 2023, at 3:04 p.m. LPN-B stated the distance from R3's room to the unsecure "employee exit" door was approximately 24 feet. On June 20, 2023, at 4:50 p.m., the surveyor observed R3 walking from the kitchen area to her room. On June 21, 2023, at 11:33 a.m., CNS/LALD-A reviewed R3's most current IAPP dated January 2, 2021, and stated one of the areas of vulnerability identified was wandering/elopement risk and one of the interventions in place to minimize this risk was to maintain a secure environment. CNS/LALD-A stated this would include securing all exit doors. The licensee's undated Wandering and Elopement policy indicated the facility had systems in place to manage wandering, minimize opportunities for elopement, and procedures in place to implement when a resident was missing or eloped. Systems in place to minimize opportunities for elopement included all doors leading outside are locked at all times and have alarms that sound when opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 640	Continued From page 20	0 640		
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 required content to include the 911 emergency number in common areas. This had the potential to affect all ten 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: On June 20, 2023, at 1:44 p.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director	0 640		

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0 640	Continued From page 21 (CNS/LALD)-A. The surveyor did not observe the 911 emergency number posted in common areas or near a cordless telephone in the kitchen area. CNS/LALD-A stated the cordless telephone in the kitchen can be used by staff, residents, or visitors. CNS/LALD-A stated the 911 emergency number was not posted near the cordless telephone and/or in common areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a two-step TST (tuberculin skin test) or other evidence of	0 660		

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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
0 660	Continued From page 22 tuberculosis (TB) screening such as a blood test for one of two employees (licensed practical nurse (LPN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The facility's TB risk assessment was completed on January 25, 2023, and was determined to be a low risk level. LPN-B was hired on February 27, 2023, to provide direct care services to the facility's residents. LPN-B's employee record included documentation of a screening completed on April 20, 2023, and a negative TST on April 23, 2023; however, a second TST was not completed. On June 21, 2023, at 2:50 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated LPN-B's second step TST had not been completed as required. The licensee's undated Tuberculosis Screening policy noted new staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs (healthcare workers). New staff will have a blood test or two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. Staff TB results will be kept in each employee medical file.	0 660		

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0 660	Continued From page 23 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 residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency	0 680		

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0 680	Continued From page 24 preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's EPP provided to the surveyor included a Hazard and Vulnerability Assessment (HVA), and generic instructions for staff to follow in case of a fire, severe weather, tornado, loss of power, bomb, water shortage, winter storm, and evacuation. The licensee's EPP did not include the following: - a quarterly review of the missing resident policy; - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems); - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being	0 680		

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0 680	Continued From page 25 evacuated; - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - the development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, volunteers; - arrangement with other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families. - an EP training and testing program On June 21, 2023, at 3:02 p.m., after a brief review of the components required in an EPP by the surveyor, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the facility's EPP was incomplete.	0 680		

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0 680	Continued From page 26 The licensee's undated Emergency Preparedness Plan - Appendix Z Compliance policy noted the intent is the EPP would be aligned with the Centers for Medicare and Medicaid Services State Operations Manual Appendix Z. The EPP will include all the elements of Appendix Z. 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;	0 730		

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0 730	Continued From page 27 (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary for one of one resident (R10) discharged from the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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:	0 730		

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0 730	Continued From page 28 The licensee's Discharge Resident Roster dated March 22, 2022, to June 20, 2023, indicated R10 was admitted to the facility on June 26, 2018, and was discharged on March 13, 2023. R10's diagnoses included Alzheimer's, gluten intolerance, and macular degeneration of the left eye. R10's service plan dated November 19, 2021, indicated R10 received the following services: medication administration, laundry, housekeeping and assistance with transferring, dressing, grooming, toileting, and bathing. R10's Progress Notes dated March 13, 2023, at 5:30 p.m., written by unlicensed personnel (ULP)-E indicated R10 was on "comfort care". R10's record lacked a discharge summary. On June 21, 2023, at 9:56 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated a discharge summary note was usually written in the resident's record by either herself or owner (O)-G. CNS/LALD-A reviewed R10's record and stated R10 did not have a discharge summary. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with	0 780		

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0 780	Continued From page 29 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 interconnected smoke alarms in the individual dwelling units throughout the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 780		

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0 780	Continued From page 30 the residents). Findings include: On a facility tour on June 20, 2023, at approximately 12:00 p.m. with licensed practical nurse (LPN)-B and broker (B)-D it was observed that smoke alarms were installed throughout the facility but were not interconnected within dwelling unit H and F so activation of any one alarm activates all alarms throughout the individual dwelling units. Smoke alarms are required to be interconnected so activation of one alarm activates all alarms throughout the dwelling unit. This deficient finding was visually verified by LPN-B and verbally verified by B-D at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 31 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide portable fire extinguishers within 75' of travel distance as required for the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 20, 2023, at approximately 11:00 a.m. with licensed practical nurse (LPN)-B it was observed that one fire extinguisher on the main floor was provided in a remote location in the facility requiring more than 75' of travel distance to the extinguisher. At least one 2-A:10-B:C rated fire extinguisher located within 75' of travel throughout the facility is required to be installed and maintained according to MN Statute 144G.45. LPN-B visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 32 (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 maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 20, 2023, at approximately 11:30 a.m. with licensed practical nurse (LPN)-B it was observed that a cover was missing from the light/ fan on the ceiling in the public restroom near resident room 6. Holes were observed in the ceiling tiles of the secondary kitchen area. Ceiling tiles are required to be maintained as installed and designed to ensure proper operation of the fire sprinkler	0 800		

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0 800	Continued From page 33 system. Storage was observed in the marked means of egress corridor near the nursing and directors' offices on the facility tour. Keeping this required means of egress clear of obstructions helps provide access to the exits for occupants and emergency responders during an emergency. Storage was observed in the marked means of egress vestibule near the main cooking kitchen on the facility tour. Keeping this required means of egress clear of obstructions helps provide access to the exits for occupants and emergency responders during an emergency. The marked exit door in the exit corridor near nursing and directors offices was observed with door locking hardware (deadbolt and locking latch) that requires more than one operation to release and open. Exit door latch hardware is required to release, unlock, and open for the purpose of exiting in one operation. It was also observed that a barrel bolt lock installed at the top and into the head jamb of the marked exit door on the south end of the east wing was used to secure the facility at night. Barrel bolt locks are not allowed and marked exit doors are required to release for the purpose of exiting with one operation. An exterior gate was observed with a fence hardware latch and did not include egress hardware for exiting. Gates or doors in the exterior exit path to the public way are required to operate with hardware on the interior of the gate, the same as the building exterior exit doors. The water heater draft hood on the water heater	0 800		

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0 800	Continued From page 34 vent was observed moved from installed position. The water heater draft hood and vent are required to be maintained according to the manufacture's installation instructions. An open electrical wiring box was observed in the crawl space access in the sprinkler riser room. Paint was observed missing causing decayed wood on the exterior trim above the window of dwelling unit G. Paint is required to be maintained for protection from the elements and decay. These deficient conditions were visually verified by LPN-B accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) 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	0 810		

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0 810	Continued From page 35 thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted on June 20, 2023, at approximately 10:30 a.m. of documents provided by and clinical nurse supervisor (CNS/LALD)-A	0 810		

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0 810	Continued From page 36 licensed practical nurse (LPN)-B on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have specific employee actions for this facility to be taken in the event of a fire or similar emergency located within the plan. The plan did include some employee actions but needed more site-specific direction. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents located within the plan. Record review of the available documentation indicated the licensee did not have unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Employee training is required to be documented separately from drills. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Record review of the available documentation indicated that evacuation drills had been conducted but not in the required sequence of twice per year per shift and at least once every	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30648	A. BUILDING: _____ B. WING _____	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEENS CARING HANDS	2525 BEMIDJI AVENUE NORTH BEMIDJI, MN 56601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 37 other month. All deficiencies were verified by CNS/LALD-A and LPN-B during the interview at approximately 1:00 p.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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 health facility identification 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: (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, R2, R7). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	0 910		

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	30648	A. BUILDING: _____ B. WING _____	06/21/2023

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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
0 910	Continued From page 38 the residents). The findings include: R1's Contract (assisted living contract) was signed by the resident's representative June 29, 2022. R2's Contract was signed by the resident's representative August 12, 2022. R7's Contract was signed by the resident's representative February 25, 2023. R1, R2, and R7's assisted living contracts did not include the provider's health facility identification number (HFID). On June 21, 2023, at 11:38 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the contract was a template contract used by the licensee for all residents. CNS/LALD-A stated the contract did not include the licensee's HFID. 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	0 920		

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0 920	Continued From page 39 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; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (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 observation, interview, and record review, the licensee failed to ensure the assisted living contract included all required content for three of three residents (R1, R2, R7). This had the potential to affect all ten residents who received assisted living 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: R1	0 920		

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0 920	Continued From page 40 R1's service plan dated October 11, 2021, indicated services included medication administration, assistance with dressing, grooming, toileting, bathing, housekeeping, and laundry. On June 21, 2023, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's scheduled morning medications. R2 R2's service plan dated August 12, 2022, indicated services included medication administration, assistance with dressing, grooming, toileting, bathing, housekeeping, and laundry. R7 R7's service plan dated February 25, 2023, indicated R7 received services to include medication administration, assistance with dressing, oral hygiene, grooming, bathing, transferring and toileting. R1, R2, and R7's Contract (assisted living contract) dated June 29, 2022, August 12, 2022, and February 25, 2023, respectively, did not include the following information: - a disclosure of the category of assisted living facility license held by the facility; - 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; - 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	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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0 920	Continued From page 41 the contract; - a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; and - disclosure of the facility's ability to provide specialized diets. On June 21, 2023, at 11:38 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the contract was a template contract used by the licensee for all residents. CNS/LALD-A stated the contract did not include the above noted content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
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	0 930		

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0 930	Continued From page 42 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 observation, interview, and record review, the licensee failed to ensure the assisted living contract included all required content for three of three residents (R1, R2, R7). This had the potential to affect all ten residents who received assisted living 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: R1 R1's service plan dated October 11, 2021, indicated services included medication administration, assistance with dressing, grooming, toileting, bathing, housekeeping, and laundry. On June 21, 2023, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's scheduled morning medications. R2 R2's service plan dated August 12, 2022, indicated services included medication	0 930		

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0 930	Continued From page 43 administration, assistance with dressing, grooming, toileting, bathing, housekeeping, and laundry. R7 R7's service plan dated February 25, 2023, indicated R7 received services to include medication administration, assistance with dressing, oral hygiene, grooming, bathing, transferring and toileting. R1, R2, and R7's Contract (assisted living contract) dated June 29, 2022, August 12, 2022, and February 25, 2023, respectively, did not include the following information: - 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; - the right undersection 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 to a transfer; and - contact information for the Office of Ombudsman of Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints. On June 21, 2023, at 11:38 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the contract was a template contract used by the licensee for all residents. CNS/LALD-A stated the contract did not include the above noted content.	0 930		

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 44 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 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	0 940		

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0 940	Continued From page 45 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 observation, interview, and record review, the licensee failed to ensure the assisted living contract included all required content for three of three residents (R1, R2, R7). This had the potential to affect all ten residents who received assisted living 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: R1 R1's service plan dated October 11, 2021, indicated services included medication administration, assistance with dressing, grooming, toileting, bathing, housekeeping, and laundry. On June 21, 2023, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's scheduled morning medications. R2 R2's service plan dated August 12, 2022, indicated services included medication administration, assistance with dressing,	0 940		

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0 940	Continued From page 46 grooming, toileting, bathing, housekeeping, and laundry. R7 R7's service plan dated February 25, 2023, indicated R7 received services to include medication administration, assistance with dressing, oral hygiene, grooming, bathing, transferring and toileting. R1, R2, and R7's Contract (assisted living contract) dated June 29, 2022, August 12, 2022, and February 25, 2023, respectively, did not include the following information: - 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; - 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; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; - 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; - contact information to obtain long-term care consulting services under section 256B.0911; and - the toll-free phone number for the Minnesota Adult Abuse Reporting Center. On June 21, 2023, at 11:38 a.m., clinical nurse	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 940	Continued From page 47 supervisor/licensed assisted living director (CNS/LALD)-A stated the contract was a template contract used by the licensee for all residents. CNS/LALD-A stated the contract did not include the above noted content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 950	Continued From page 48 subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing for three of three residents (R1, R2, R7). This had the potential to affect all ten residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1's diagnoses included hypothyroidism (underactive thyroid), hypertension (HTN-high blood pressure), and osteoporosis. R1's service plan dated October 11, 2021, indicated services included medication administration, assistance with dressing, grooming, toileting, bathing, housekeeping, and laundry. R2 R2's diagnoses included dementia, congestive heart failure (condition in which the heart's function as a pump is inadequate to meet the body's needs), depression, and chronic	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 950	Continued From page 49 obstructive pulmonary disease (COPD-chronic inflammatory lung disease that causes obstructed airflow from the lungs). R2's service plan dated August 12, 2022, indicated services included medication administration, assistance with dressing, grooming, toileting, bathing, housekeeping, and laundry. R7 R7's diagnoses included dementia, anxiety, psychotic disturbance, HTN and insomnia. R7's service plan dated February 25, 2023, indicated R7 received services to include medication administration, assistance with dressing, oral hygiene, grooming, bathing, transferring and toileting. R1, R2, and R7's records did not include evidence of a notice with the required statutory language for the resident to identify a designated representative or documentation R1, R2 and/or R7 declined to name a designated representative. On June 21, 2023, at 11:45 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated she was unaware of this regulation and none of the residents at the facility had been provided the opportunity to identify or decline to identify a designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01290	Continued From page 50	01290		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure background studies were conducted prior to staff providing services, for one of nine employees (unlicensed personnel (ULP)-F). 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). This practice resulted in an immediate correction order on June 21, 2023, at approximately 9:30 a.m.	01290		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEENS CARING HANDS	2525 BEMIDJI AVENUE NORTH BEMIDJI, MN 56601

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01290	Continued From page 51 The findings include: ULP-F had a hire date of April 8, 2023. ULP-F's employee record lacked evidence of a completed background clearance letter. On June 20, 2023, at 2:01 p.m., the surveyor observed ULP-F provide incontinence care for R1. At 2:12 p.m., the surveyor observed ULP-F and ULP-E transfer R4 with a sit to stand mechanical lift from her wheelchair to the toilet. On June 21, 2023, at 7:42 a.m., ULP-F stated she works on the floor providing cares to the residents. On June 21, 2023, at clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee did not have a background study clearance letter for ULP-F. CNS/LALD-A stated ULP-F was hired on April 8, 2023, for a full-time day position. CNS/LALD-A stated ULP-F has been working on the floor providing care to residents since May 2, 2023. The licensee's undated Employee Records policy noted employee records for each person will include documentation of a completed criminal background study. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed by evaluation supervisor on June 21, 2023, at 4:18 p.m., however, non-compliance remains at a scope and level of three, isolated (G).	01290		

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01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one unlicensed personnel (ULP-F). 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	01440		

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01440	Continued From page 53 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired on April 18, 2023, to provide direct care services to the facility's residents. On June 20, 2023, at 2:12 p.m., the surveyor observed ULP-F and ULP-E, using appropriate technique, transfer R4 from her wheelchair to the toilet using a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability). ULP-F's employee record did not include documentation of a registered nurse (RN) supervising ULP-F performing a delegated task within 30 days of beginning work with the licensee. On June 21, 2023, at 2:47 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated she had not "completed" a 30-day supervision on ULP-F. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	01640		

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01640	Continued From page 54 that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans were updated for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01640		

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01640	Continued From page 55 R1's diagnoses included hypothyroidism (underactive thyroid), hypertension (HTN-high blood pressure), and osteoporosis. R1's prescriber orders dated December 23, 2021, included an order for oxygen therapy two liters per nasal cannula (a thin flexible tube which on one end splits into two prongs that are placed in the nostrils and from which a mixture of air and oxygen flow) at rest and exertion. On June 21, 2023, at 8:04 a.m., the surveyor observed R1 laying in her bed with a nasal cannula properly placed. R1 was receiving oxygen therapy at two liters via an oxygen concentrator. R1's service plan dated October 11, 2021, indicated R1 received wound care and catheter care treatments. R1's service plan did not include oxygen therapy. On June 21, 2023, at 12:06 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R1 no longer had a catheter or was being provided wound care. CNS/LALD-A stated R1's service plan did not include oxygen therapy which R1 received. CNS/LALD-A stated R1's service plan had not been revised to include oxygen therapy and to remove the treatments R1 no longer received. The licensee's undated Service Plan policy indicated service plans will be revised, if needed, based on resident reassessments and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION:	01640		

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01640	Continued From page 56 Twenty-One (21) days	01640		
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 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	01690		

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01690	Continued From page 57 by: Based on observation, interview, and record review, the licensee failed to ensure the security and accountability of controlled substances were maintained for two of two residents (R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 20, 2023, at 9:47 a.m., during the entrance conference clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated all narcotic medication was double locked and counted at the end of each shift. On June 20, 2023, at 10:32 a.m., the surveyor toured the facility with licensed practical nurse (LPN)-B, including a review of the locked narcotic box in the locked medication refrigerator. The narcotic box contained the following medications which LPN-B visualized the medication bottles and syringes and stated the below noted amounts: - one opened bottle of morphine sulfate (narcotic pain medication) 100 milligrams (mg)/5 milliliters (ml) containing 2 ml for R2 - one unopened bottle of morphine sulfate 100 mg/5 ml containing 30 ml for R2 - 15 preset syringes of morphine sulfate 0.1 ml (2 mg) for R5 - one opened bottle of morphine sulfate 100 mg/5	01690		

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01690	Continued From page 58 ml containing 19 ml for R5 On June 20, 2023, at 10:39 a.m., the surveyor asked LPN-B for the narcotic logs for the above noted medications. LPN-B stated the above noted narcotics were not being counted. On June 20, 2023, at 1:10 p.m., CNS/LALD-A stated according to the facility's policy all narcotics should be counted every shift. The licensee's undated Medication Storage policy indicated scheduled II drugs would be counted at the beginning and end of every shift, with counts compared to Schedule II medications ordered to be administered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of one	01710		

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01710	Continued From page 59 resident (R1) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 20, 2023, at 9:46 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee provided medication management services to the residents at the facility. R1's diagnoses included hypothyroidism (underactive thyroid), hypertension (HTN-high blood pressure), and osteoporosis. R1's service plan dated October 11, 2021, indicated R1 received services which included medication administration. R1's prescriber orders dated September 24, 2021, January 21, 2022, and February 16, 2022, included one anticoagulant, one antibiotic, two antihypertensive medication, one heart health medication, one laxative, one mild pain reliever, one thyroid hormone replacement medication, and three vitamin/mineral supplements. On June 21, 2023, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's scheduled morning medications.	01710		

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01710	Continued From page 60 R1's record indicated a face-to-face medication administration assessment had been completed on October 8, 2021. R1's record did not include an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. On June 21, 2023, at 11:52 a.m., CNS/LALD-A reviewed R1's record and stated R1 had not had a medication management reassessment completed since the initial assessment dated October 8, 2021. CNS/LALD-A stated she should be conducting this reassessment at each 90-day reassessment; however, she has not been doing this. CNS/LALD-A stated this would be the same for all residents at the facility. The licensee's undated Medication and Treatment - Administration and Delegation policy indicated prior to a ULP providing delegated medication administration the RN must conduct a face-to-face resident assessment to determine what mediation management services would be provided and how those services would be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan	01730		

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

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01730	Continued From page 62 medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to annually review the individualized medication management plan for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 20, 2023, at 9:46 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee provided medication management services to the residents at the facility. R1's diagnoses included hypothyroidism (underactive thyroid), hypertension (high blood pressure), and osteoporosis. R1's service plan dated October 11, 2021, indicated R1 received services which included medication administration. R1's prescriber orders dated September 24, 2021, January 21, 2022, and February 16, 2022, included one anticoagulant, one antibiotic, two antihypertensive medication, one heart health	01730		

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01730	Continued From page 63 medication, one laxative, one mild pain reliever, one thyroid hormone replacement medication, and three vitamin/mineral supplements. On June 21, 2023, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's scheduled morning medications. R1's most recent Medication/Treatment/Therapy Individual Management Plan was dated October 8, 2021. R1's record lacked a current and updated medication management plan reviewed annually to include the following: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensure that medication refills are ordered on a timely basis; - procedures for staff notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with medication management services; - 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; and - completion of medication reconciliation. On June 21, 2023, at 11:59 a.m., CNS/LALD-A stated R1's medication management plan had not been updated since October 8, 2021. CNS/LALD-A stated, "I suppose it should be completed annually". No further information was provided.	01730		

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01730	Continued From page 64 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of one resident (R1) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01760		

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COLLEENS CARING HANDS	2525 BEMIDJI AVENUE NORTH BEMIDJI, MN 56601

(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 65 The findings include: R1's diagnoses included hypothyroidism (underactive thyroid), hypertension (HTN-high blood pressure), and osteoporosis. R1's service plan dated October 11, 2021, indicated R1 received services which included medication administration. R1's prescriber orders dated December 4, 2021, included the following orders: - Lopressor 50 milligrams (mg) to be administered every morning; and 25 mg to be administered every evening - vitamin D3 2000 units one tablet to be administered daily On June 21, 2023, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's scheduled morning medications. R1's June 1, 2023, through June 21, 2023, medication administration record (MAR) did not include documentation the above noted medications had been administered as prescribed. Nor did R1's record include orders to discontinue the Lopressor and vitamin D3 medication. On June 23, 2023, at 12:18 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated she was unable to find prescriber orders to discontinue R1's Lopressor and vitamin D3 which had been ordered on December 4, 2021. The licensee's undated Medication and Treatment Orders - Implementing policy indicated medication and treatment/therapy orders received	01760		

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01760	Continued From page 66 by the licensee must be implemented per the provider's orders. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01760		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to renew prescriptions at least every 12 months for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 20, 2023, at 9:46 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee provided	01830		

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01830	Continued From page 67 medication management services to the residents at the facility. R1's diagnoses included hypothyroidism (underactive thyroid), hypertension (HTN-high blood pressure), and osteoporosis. R1's service plan dated October 11, 2021, indicated R1 received services which included medication administration. R1's prescriber orders included the following medications and the dates the orders were signed: - Eliquis 5 milligrams (mg) (blood thinner) twice daily (signed January 21, 2022) - Senna plus 8.6 - 5m mg (laxative) one tablet daily (signed October 3, 2022) - Norvasc 2.5 mg (antihypertensive) daily (signed December 4, 2021) - cerovite senior tablet (vitamin) one tablet daily (signed dated December 4, 2021) - levothyroxine 25 mg (thyroid hormone replacement) take one tablet on Monday, Wednesday, and Friday; take two tablets on Sunday, Tuesday, Thursday and Saturday (signed December 4, 2021) - Miralax 17 grams (gm) in 4-8 ounces of water daily (signed February 16, 2022) - Septra DS (antibiotic) one tablet daily (signed January 21, 2022) - calcium 600 mg twice daily (signed December 4, 2021) R1's June medication administration record (MAR) listed medications as prescribed above, times to administer, and staff initials to indicate the medications had been given. On June 21, 2023, at 8:04 a.m., the surveyor	01830		

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01830	Continued From page 68 observed unlicensed personnel (ULP)-E administer R1's scheduled morning medications. On June 21, 2023, at 10:30 a.m., CNS/LALD-A stated R1's medication should have been renewed annually. The licensee's undated Medication and Treatment Orders - Renewal indicated medication and treatment orders must be renewed at least every 12 months or more frequently as required. No further information. TIME PERIOD OF CORRECTION: Seven (7) days	01830		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three residents (R2, R4, R5) medications were stored according to manufacturer's recommended temperatures and failed to ensure the medication refrigerator maintained an acceptable temperature. 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	01880		

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01880	Continued From page 69 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 20, 2023, at 10:15 a.m., the surveyor toured the facility with licensed practical nurse (LPN)-B, including a review of the locked medication refrigerator. LPN-B stated the current temperature of the refrigerator was 46 degrees Fahrenheit (F). The refrigerator contained the following medications: - two Bisacodyl 10 milligram (mg) suppositories for R2 - two Bisacodyl 10 mg suppositories for R4 The locked narcotic box in the medication refrigerator contained the following medications: - 15 preset syringes of morphine sulfate (narcotic pain medication) 0.1 milliliter (ml) (2 mg) for R5 - one opened bottle of morphine sulfate 100 mg/5 ml containing 19 ml for R5 - one opened bottle of morphine sulfate 100 mg/5 ml containing 2 ml for R2 - one unopened bottle of morphine sulfate 100 mg/5 ml containing 30 ml for R2 On June 20, 2023, at 10:21 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the above noted medications were usually stored in the medication refrigerator. On June 20, 2023, at 1:09 p.m., the Daily Refrigerator Temperature Log dated October 18, 2021, through April 20, 2023, was reviewed with CNS/LALD-A. The directions at the top of the log indicated the refrigerator temperature should be	01880		

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01880	Continued From page 70 checked monthly with the acceptable range 36 - 46 degrees F. If the temperature was out of range the staff should notify owner (O)-G or the registered nurse (RN). Out of the four recorded temperatures for 2023, three out of the four temperatures were recorded as below 35 degrees F (34 degrees F). CNS/LALD-A stated the last time the medication refrigerator had been checked was on April 20, 2023, and stated she realized now the temperatures were below the acceptable range. The manufacturer's instructions for Bisacodyl suppositories dated November 21, 2022, indicated suppositories should be stored at room temperature (59 - 86 degrees F). The manufacturer's instructions for liquid morphine sulfate dated January 2012, indicated the medication should be stored at room temperature (59 - 86 degrees F). The licensee's undated Medications Storage policy indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the	01890		

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01890	Continued From page 71 expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of two residents (R3, R9) and failed to monitor for expired medications for one of five residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 20, 2023, at 1:30 p.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A, including a review of the locked medication cupboard. CNS/LALD-A observed and confirmed the following: TIME SENSATIVE MEDICATION R3's calcitonin salmon nasal spray (medication to treat osteoporosis) 200 units did not have a label which indicated the date the nasal spray had been opened and when the solution would expire. ORIGINAL PRESCRIPTION LABEL R9's bottles of brimonidine tartrate ophthalmic	01890		

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01890	Continued From page 72 solution 0.2% (glaucoma medication) and timolol maleate ophthalmic solution 0.5% (glaucoma medication) lacked original prescription labels with information regarding the directions for use, medication dosage, resident's name, and the pharmacy in which it had been issued. EXPIRED MEDICATION R3's opened bottle of nitroglycerine (medication to treat chest pain) 0.4 milligrams (mg) expired February 2021. On June 20, 2023, at 1:35 p.m., CNS/LALD-A stated all medications should be labeled appropriately, dated when opened when needed and expired medications should be destroyed. CNS/LALD-A stated she was unsure of how these above noted medications had been overlooked. The manufacturer's instructions for calcitonin salmon nasal spray dated September 2017, indicated an open bottle should be stored at room temperature in an upright position up to 35 days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	01940		

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01940	Continued From page 73 individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1) who had treatments managed by the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01940		

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01940	Continued From page 74 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 20, 2023, at 9:50 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee provided treatment services to residents at the facility. R1's diagnoses included hypothyroidism (underactive thyroid), hypertension (HTN-high blood pressure), and osteoporosis. R1's prescriber orders dated December 23, 2021, included an order for oxygen therapy 2 liters per nasal cannula (a thin flexible tube which on one end splits into two prongs that are placed in the nostrils and from which a mixture of air and oxygen flow) at rest and exertion. On June 21, 2023, at 8:04 a.m., the surveyor observed R1 laying in her bed with a nasal cannula properly placed. R1 was receiving oxygen therapy at 2 liters via an oxygen concentrator. R1's Individualized Treatment or Therapy Management Plan dated December 22, 2021, for oxygen therapy did not include: - a written statement on the service plan of the treatment or therapy services R1 received - identification of treatment or therapy tasks that would be delegated to unlicensed personnel (ULP) - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed. In addition, R1's	01940		

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01940	Continued From page 75 treatment plan for oxygen therapy had not been reviewed since December 22, 2021. On June 21, 2023, at 12:09 p.m., CNS/LALD-A stated R1's treatment and therapy plan for oxygen therapy was incomplete as it did not include the above noted required content. In addition, CNS/LALD-A stated R1's Individualized Treatment Plan had not been updated since December 22, 2021, and it should be reviewed and updated annually. The licensee's undated Medication and Treatment - Administration and Delegation policy indicted prior to a ULP providing delegated treatments/therapy, the RN must conduct a face-to-face assessment to determine what treatment/therapy services that will be provided to the resident. The licensee will prepare and include in the Service Plan a written statement of the treatment/therapy services that will be provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must	01960		

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01960	Continued From page 76 document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure treatment or therapy services were documented for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included hypothyroidism (underactive thyroid), hypertension (HTN-high blood pressure), and osteoporosis. R1's service plan dated October 11, 2021, had not been updated to include oxygen therapy as a treatment provided. R1's prescriber orders dated December 23, 2021, included an order for oxygen therapy 2 liters per nasal cannula (a thin flexible tube which on one end splits into two prongs that are placed in the nostrils and from which a mixture of air and oxygen flow) at rest and exertion. On June 21, 2023, at 8:04 a.m., the surveyor observed R1 laying in her bed with a nasal	01960		

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01960	Continued From page 77 cannula properly placed. R1 was receiving oxygen therapy at 2 liters via an oxygen concentrator. R1's June 1, 2023, through June 21, 2023, medication administration record (MAR) directed staff to change R1's nasal cannula once weekly on Mondays; and to change the long oxygen tubing once a month. R1's record lacked documentation oxygen therapy had been administered at 2 liters as prescribed. On June 21, 2023, at 12:03 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R1's record lacked documentation oxygen therapy was being administered at 2 liters as prescribed. The licensee's undated Medication and Treatment Record - Documentation and Refusal policy indicated documentation of treatment administration would be completed by the person who performed the task immediately after completed. If treatment/therapy assistance was not completed as prescribed, documentation must include the reason why it was not completed, and any follow up procedures provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or	01970		

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01970	Continued From page 78 electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to renew treatment orders at least every 12 months for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 20, 2023, at 9:50 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated the licensee provided treatment services to residents at the facility. R1's diagnoses included hypothyroidism (underactive thyroid), hypertension (HTN-high blood pressure), and osteoporosis. R1's service plan dated October 11, 2021, did not include oxygen therapy as a treatment service the	01970		

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	30648	A. BUILDING: _____ B. WING _____	06/21/2023

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01970	Continued From page 79 resident was receiving. R1's prescriber orders dated December 23, 2021, included an order for oxygen therapy 2 liters per nasal cannula (a thin flexible tube which on one end splits into two prongs that are placed in the nostrils and from which a mixture of air and oxygen flow) at rest and exertion. On June 21, 2023, at 8:04 a.m., the surveyor observed R1 laying in her bed with a nasal cannula properly placed. R1 was receiving oxygen therapy at 2 liters via an oxygen concentrator. On June 21, 2023, at 12:01 p.m., CNS/LALD-A stated she was unable to find a more current order for R1's oxygen therapy than the one dated December 23, 2021. CNS/LALD-A stated all treatment orders should be renewed annually. The licensee's undated Medication and Treatment Orders - Renewal indicated treatment orders must be renewed at least every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety	02040		

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02040	Continued From page 80 risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted June 20, 2023, at approximately 10:30 a.m. with clinical nurse supervisor (CNS/LALD)-A and licensed practical nurse (LPN)-B on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property.	02040		

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02040	Continued From page 81 This deficient condition was verified by LPN-B and CNS/LALD-A during the interview at approximately 1:00 p.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for two of two residents (R1, R2) with a hospital bedrail. In addition, the licensee failed to safely store strong chemicals which had the potential to affect all 10 residents, staff, and visitors; and failed to safety store oxygen for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	02310		

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02310	Continued From page 82 The findings include: This resulted in an immediate correction order on June 20, 2023, at approximately 4:47 p.m. BEDRAILS R1 R1's diagnoses included pneumonia, hypertension (HTN - high blood pressure), and osteoporosis. On June 20, 2023, at 2:01 p.m., the surveyor observed R1 laying in her bed. R1's hospital bed had one upper bedrail in the upright position on the right side of her bed with the left side of the bed tight up against the wall. R1's Service Plan dated October 11, 2021, indicated R1 required assistance with dressing, bathing, toileting, grooming, and transferring. R1's assessment dated April 4, 2023, indicated R1was confused and had poor decision-making ability; R1 was in bed most of the time; was incontinent; and had one bedrail on her bed to assist with bed mobility. R1's Physical Device Assessment dated April 4, 2023, indicated R1 had a half bedrail on her bed. R1 had cognitive deficit or dementia, and poor balance/unsteady gait. R1 was able to grab onto the bedrail and help reposition. The bedrails were considered a therapeutic intervention to achieve proper body positioning, balance and/or alignment. The risks and benefits of having the bedrail had been verbally reviewed and handout provided to the resident and the resident's family. R1's record lacked a comprehensive assessment	02310		

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02310	Continued From page 83 on the use of an assistive device to include actual measurements of the entrapment zones and information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device. R2 R2's diagnoses included dementia, congestive heart failure (condition in which the heart's function as a pump is inadequate to meet the body's needs), depression, and chronic obstructive pulmonary disease (COPD-chronic inflammatory lung disease that causes obstructed airflow from the lungs). On June 20, 2023, at 2:10 p.m., the surveyor observed R2 in her room, seated in a chair. R2's bed was observed to be a hospital bed with bilateral quarter upper bedrails in the raised position. R2's Service Plan dated August 12, 2022, indicated R2 required assistance with dressing, grooming, toileting, bathing, and transferring. R2's assessment dated February 24, 2023, indicated R2 had severe cognitive impairment, was incontinent of both bladder and bowel, and had bedrails on her bed to assist with bed mobility. R2's Physical Device Assessment dated February 24, 2023, indicated R2 had a half-sided bedrails on her bed. R2 had cognitive deficit or dementia and poor balance/unsteady gait. R2 was able to hold onto bedrail for support and stability to assist with repositioning. The risks and benefits of having the bedrail had been verbally reviewed and handout provided to the resident and the resident's family.	02310		

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02310	Continued From page 84 R2's record lacked a comprehensive assessment on the use of an assistive device to include actual measurements of the entrapment zones and information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device. On June 20, 2023, at 1:59 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A stated R1 and R2's Physical Device Assessments did not include zone measurements. CNS/LALD-A stated, "I just know they are hospital beds." CNS/LALD-A stated she was unaware of the Food and Drug Administration (FDA) entrapment zones for bedrails. On June 20, 2023, at 2:09 p.m., CNS/LALD-A measured R1's bedrail with surveyor present. The bedrail measured 2.75 inches tall by 9.5 inches wide at the largest open area. The measurement between the mattress and the bedrail was 1.5 inches. CNS/LALD-A placed pressure on the bedrail and stated it was securely fastened to the hospital bed. CNS/LALD-A stated R1's bedrail was used to assist with positioning. On June 20, 2023, at 2:12 p.m., CNS/LALD-A measured R2's bedrail with the surveyor present. The bedrail measured 2.75 inches tall by 9.5 inches wide at the largest open area. The measurement between the mattress and the bedrail was 1.5 inches. The measurement of the gap between the top of the bed and the bedrail was 3 inches. CNS/LALD-A placed pressure on the bedrail and stated it was securely fastened to the hospital bed. CNS/LALD-A stated R2's bedrail was used to assist with positioning.	02310		

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02310	Continued From page 85 The licensee's undated Orientation and Training - Siderails policy noted the responsibility of the assisted living provider was to assess the resident's cognitive and physical abilities, including the ability to call for help if entrapment occurs; assess compliance with and maintain the siderails, according to manufacturer's instructions and FDA dimensional guidance and educate the resident and/or representative on the risk of entrapment, including injury and death. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated June 20, 2023, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint."	02310		

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02310	Continued From page 86 Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. STORAGE OF CHEMICALS The licensee held an assisted living with dementia care license. On June 20, 2023, at 11:05 a.m., the surveyor toured the facility with licensed practical nurse (LPN)-B which included an unsecured hallway and storage closets approximately 10 steps away from R3's room. LPN-B opened the unlocked storage closet labeled "A". Closet "A" contained several shelves containing the following items (not an inclusive list): - one open gallon can of Klean Strip paint thinner - one bottle of Mean Green Super strength cleaner and degreaser (40 fluid ounces)	02310		

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02310	Continued From page 87 - one can of Drano Liquid Drain Cleaner (18 ounces) - one plastic jug of Ortho Insect Killer - one opened gallon jug of DMQ Neutral Disinfectant Cleaner On June 20, 2023, at 11:40 a.m., CNS/LALD-A stated residents currently would have access to anything in storage closet "A". CNS/LALD-A stated the door to the storage closet should be locked. The Klean Strip Paint Thinner Safety Data Sheet dated April 20, 2015, indicated may be fatal if swallowed and enters airways. Store locked up. The Mean Green Super Strength cleaner Safety Data Sheet dated May 9, 2022, indicated the cleaner could cause severe skin burns and eye damage. The Drano Liquid Drian Cleaner Safety Data Sheet dated March 4, 2015, indicated the product could cause severe skin burns and eye damage. Store locked up. The Ortho Insect Killer Safety Data Sheet dated November 24, 2013, indicated one should avoid inhalation and contact with skin, eyes, or clothing. Store in a well-ventilated area inaccessible to children. The DMQ Neutral Disinfectant Cleaner Safety Data Sheet dated July 27, 2015, indicated the cleaner could cause skin irritation and severe eye damage. OXYGEN STORAGE On June 20, 2023, at 1:15 p.m., the surveyor toured the facility with CNS/LALD-A.	02310		

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02310	Continued From page 88 CNS/LALD-A stated R1 had oxygen stored in her room. The surveyor observed in R1's closet three tall oxygen cylinders. One oxygen cylinder was securely stored in a holder. The other two oxygen cylinders were in the upright position against the wall with stacks of clothing and blankets on the floor of the closet up against the oxygen cylinders. These two oxygen cylinders were not stored securely in a holder. On June 20, 2023, at 1:17 p.m., CNS/LALD-A stated R1's oxygen should not be stored in her closet and should be stored securely in a stand/holder. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by evaluation supervisor on June 21, 2023, at 3.29 p.m., however, non-compliance remains at a scope and level of two, widespread (F).	02310		
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as	02410		

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02410	Continued From page 89 related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two residents' (R7, R8) privacy was respected with regards to electronic monitoring. 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:	02410		

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02410	Continued From page 90 R7 R7's diagnoses included dementia, anxiety, psychotic disturbance, hypertension (HTN-high blood pressure) and insomnia. R7's service plan dated February 25, 2023, indicated R7 received services to include medication administration, assistance with dressing, oral hygiene, grooming, bathing, transferring and toileting. R7's assessment dated April 27, 2023, indicated R7 had severe cognitive impairment, was a risk for falls, had partial incontinence of bowel and bladder, and required assistance with dressing, grooming, bathing, toileting and transferring. R8 R8's diagnoses included Alzheimer's disease, anxiety, atrial fibrillation (irregular often fast heartrate), HTN, and history of suicidal behavior. R8's service plan dated December 12, 2022, indicated R8 received services to include medication administration, assistance with dressing, grooming, bathing, and toileting. R8's assessment dated March 1, 2023, indicated R8 had severe cognitive impairment, was a risk for falls, a high elopement risk, was partially incontinent of bladder, and required assistance with dressing, grooming, and bathing. On June 20, 2023, at 1:23 p.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. The surveyor observed on the open kitchen counter two electronic monitors. The screens of the monitors were facing towards	02410		

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02410	Continued From page 91 the open hallway and dining room area and could be visualized by any staff, visitor, or resident in the area. Both monitors were turned on. CNS/LALD-A stated the monitors were for R7 and R8. CNS/LALD-A stated both monitors had audio and live feed video capability. CNS/LALD-A stated the live feed video could not be accessed on any other electronic device other than the monitor. CNS/LALD-A stated the monitors had been placed in the resident's rooms as they were both a fall risk. CNS/LALD-A stated the monitors were in a public area and could be visualized by staff, visitors, or other residents. The licensee's undated Video and Photography policy indicated it is the policy of [name of licensee], consistent with its respect for resident privacy and confidentiality, to provide clear and concise guidelines to obtain consent to photograph, video, or audio record residents and/or staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		
03070 SS=F	144.6502, Subd. 6 Form Requirements (b) Facilities must make the notification and consent form available to the residents and inform residents of their option to conduct electronic monitoring of their rooms or private living unit. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	03070		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEENS CARING HANDS	2525 BEMIDJI AVENUE NORTH BEMIDJI, MN 56601

(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
03070	Continued From page 92 review, the licensee failed to obtain consent for electronic monitoring for two of two residents (R7, R8) who had an electronic monitor device in place. 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: R7 R7's diagnoses included dementia, anxiety, psychotic disturbance, hypertension (HTN-high blood pressure) and insomnia. R7's service plan dated February 25, 2023, indicated R7 received services to include medication administration, assistance with dressing, oral hygiene, grooming, bathing, transferring and toileting. R7's assessment dated April 27, 2023, indicated R7 had severe cognitive impairment, was a risk for falls, had partial incontinence of bowel and bladder, and required assistance with dressing, grooming, bathing, toileting and transferring. R8 R8's diagnoses included Alzheimer's disease, anxiety, atrial fibrillation (irregular often fast heartrate), HTN, and history of suicidal behavior. R8's service plan dated December 12, 2022, indicated R8 received services to include	03070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30648	A. BUILDING: _____ B. WING _____	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEENS CARING HANDS	2525 BEMIDJI AVENUE NORTH BEMIDJI, MN 56601

(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
03070	Continued From page 93 medication administration, assistance with dressing, grooming, bathing, and toileting. R8's assessment dated March 1, 2023, indicated R8 had severe cognitive impairment, was a risk for falls, a high elopement risk, was partially incontinent of bladder, and required assistance with dressing, grooming, and bathing. On June 20, 2023, at 1:23 p.m., the surveyor toured the facility with clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. The surveyor observed on the open kitchen counter two electronic monitors. The screens of the monitors were facing towards the open hallway and dining room area and could be visualized by any staff, visitor, or resident in the area. Both monitors were turned on. CNS/LALD-A stated the monitors were for R7 and R8. CNS/LALD-A stated both monitors had audio and live feed video capability. CNS/LALD-A stated the monitors had been placed in the resident's rooms as they were both a fall risk. R7 and R8's records lacked a written consent for the electronic monitoring devices placed in their rooms. On June 20, 2023, at 1:57 p.m., CNS/LALD-A stated R7 and R8 did not have written consent for electronic monitoring. The licensee's undated Video and Photography policy indicated all photographs and/or video taping of residents and/or staff are not permitted without expressed consent. A signed consent form is to be kept in the resident record. No further information was provided.	03070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30648	A. BUILDING: _____ B. WING _____	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEENS CARING HANDS	2525 BEMIDJI AVENUE NORTH BEMIDJI, MN 56601

(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
03070	Continued From page 94 TIME PERIOD FOR CORRECTION: Seven (7) days	03070		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *06/20/23*
Time: 10:57:08
Report: 3822231075

Food and Beverage Establishment Inspection Report

Location:
Colleen's Caring Hands
2525 Bemidji Avenue
Bemidji, MN56601
Beltrami County, 04

Establishment Info:
ID #: 0023088
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Colleen Hill-Kjos
Phone #: 2183338852
ID #: 29374

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.

4-100 Equipment Construction Materials

4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

OBSERVED CONTACT MATERIAL UNDER DISH STORAGE IN CABINETS, REMOVE.

Comply By: 06/21/23

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.

OBSERVED MISSING KNOBS ON CABINETS, REPLACE.

Comply By: 06/26/23

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Chlorine: = 200 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *06/20/23*
Time: 10:57:08
Report: 3822231075
Colleen's Caring Hands

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: <41 Degrees Fahrenheit - Location:
Violation Issued: No

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

SAME DAY SERVICE, EGGS AND MEAT FULLY COOKED.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 3822231075 of 06/20/23.

Certified Food Protection Manager: Alicia Lauderbaugh

Certification Number: FM101742 Expires: 11/12/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Jackie Welch
Staff

Signed: _____
Dave Kaufman
RS
651-201-4500
health.foodlodging@state.mn.us