Electronically Delivered

November 27, 2023

Licensee
Ostrander Assisted Living
309 Minnesota Street
Ostrander, MN 55961

RE: Project Number(s) SL30336015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 7, 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.

The MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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 . . ."

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

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:

https://www.web.health.state.mn.us/form/HRD-Appeals-Form

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30336	A. BUILDING: _____ B. WING _____	11/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSTRANDER ASSISTED LIVING	309 MINNESOTA STREET OSTRANDER, MN 55961

(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(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: SL30336015-0 On November 6, 2023, through November 7, 2023, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three active residents; two receiving services under the Assisted Living license.	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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 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 licensed assisted living director (LALD)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On November 6, 2023, at 8:21 a.m. the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-A currently held a LALD license effective through October 31, 2024; however, LALD-A was not listed as the Director of Record for the licensee. On November 6, 2023, at 11:45 a.m. LALD-A reviewed the BELTSS website with the surveyor and confirmed she was not listed as the director of record and further stated she hadn't realized she needed to add that.	0 110		

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0 110	Continued From page 2 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	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; (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:	0 470		

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0 470	Continued From page 3 Based on observation, interview, and record review, the licensee failed to ensure the staffing schedule was posted with the required content. This had the potential to affect the licensee's current resident, staff, and any visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an Assisted Living license, was licensed for a capacity of six residents, and at the time of the survey had a census of three residents. On November 6, 2023, at 1:30 p.m. the surveyor observed the main entry area and resident common areas of the building. There was no staff schedule observed. On November 7, 2023, at 7:58 a.m. clinical nurse supervisor (CNS)-B stated there was not a staffing plan posted. CNS-B indicated a schedule was posted in the attached nursing home, but not in the assisted living building. The licensee's undated, Staffing, Direct-Care Staffing Plan & Daily Schedule policy noted the schedule would be posted at the beginning of the shift in a central location in each building accessible to staff, residents, volunteers, and the	0 470		

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0 470	Continued From page 4 public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
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, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and 911 emergency number as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 640		

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0 640	Continued From page 5 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: The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility; and - post information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On November 6, 2023, at 1:30 p.m. the surveyor observed the main entry area and resident common areas of the building. There was no posting of the 911 emergency number or information and reporting number for MAARC, as required. On November 7, 2023, at 7:58 a.m. clinical nurse supervisor (CNS)-B stated the 911 emergency number and the MAARC information was not posted. CNS-B indicated she was not aware of the requirement. The licensee's undated, Assisted Living Required Postings and Disclosures document identified postings required: -911 (common areas and by phones provided by the facility) -MN (Minnesota) Adult Abuse Reporting Center Information and reporting number. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 640		

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0 640	Continued From page 6 (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of one employee (licensed practical nurse (LPN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 650		

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0 650	Continued From page 7 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: LPN-D started employment on March 16, 2020. On November 7, 2023, at 7:32 a.m. LPN-D was observed to administer medications to R1. LPN-D's employee record included a performance evaluation dated November 18, 2021. LPN-D's record lacked evidence of the following: - documentation of annual performance reviews that identify areas of improvement needed and training needs; and -current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. On November 7, 2023, at 3:00 p.m. office manager (OM)-E stated the above content was missing from LPN-D's employee record. OM-E stated annual performance reviews and job descriptions should be up to date and in the employee record. The licensee's undated, Personnel Records policy noted the personnel record for each person would include: i. Performance evaluations which identify areas of improvement needed and training needs [performance reviews must be conducted at least	0 650		

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0 650	Continued From page 8 annually]; and j. Current job description, which includes qualifications, responsibilities, and identification of supervisors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom	0 660		

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0 660	Continued From page 9 screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test, for one of one employee (licensed practical nurse (LPN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or 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 August 16, 2023, and was determined to be a low risk level. LPN-D began providing direct care service for the licensee on March 16, 2020. LPN-D's record lacked evidence of TB testing completed upon hire. A TB history and symptom screen had been completed on March 29, 2022; however, no TST or IGRA (TB blood test) had been completed. On November 7, 2023, at 3:25 p.m. office manager (OM)-E stated there were no TST results in LPN-D's employee file. On November 7, 2023, at 4:15 p.m. clinical nurse supervisor (CNS)-B stated she couldn't figure out where LPN-D's documented TSTs were but would administer a first step TST today.	0 660		

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0 660	Continued From page 10 The licensee's undated, TB Prevention and Control policy noted upon hire all staff are tested for tuberculosis with either a two-step Mantoux (skin test) or an IGRA laboratory blood test. The results of the TB test will be recorded and kept in the employee's medical file. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies 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	0 680		

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0 680	Continued From page 11 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to practice and document testing of it's emergency preparedness (EP) plan at least twice annually as required, post an emergency disaster plan prominently, have a written EP plan with all the required content, and evaluate its missing person policy at least quarterly. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 680		

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0 680	Continued From page 12 EP PLAN TESTING The EP plan lacked evidence the facility had tested its EP plan, conducted and/or participated in a full-scale community-based exercise, or conducted a tabletop exercise to test it's plan and document the results of testing at least twice annually as required. On November 7, 2023, at 2:30 p.m. director of maintenance (DM)-C stated the facility had participated in a full-scale community-based event on November 20, 2022, but had not conducted any additional testing in the past year. EMERGENCY DISASTER PLAN POSTED The licensee failed to prominently post the emergency disaster plan. On November 6, 2023, at 1:30 p.m. observation of the facility identified no posted facility emergency disaster plan. On November 7, 2023, at 7:58 a.m. clinical nurse supervisor (CNS)-B stated the emergency preparedness plan was not posted anywhere. CNS-B further stated she was not aware of the requirement adding the EP binder was kept in the business office. EMERGENCY PREPAREDNESS PLAN CONTENT The licensee's emergency preparedness plan consisted of several documents and policies in a white three-ringed binder dated May 29, 2023. The book included a risk assessment, a communication plan, training, testing, and various policies/procedures.	0 680		

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	30336	A. BUILDING: _____ B. WING _____	11/07/2023

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OSTRANDER ASSISTED LIVING	309 MINNESOTA STREET OSTRANDER, MN 55961

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0 680	Continued From page 13 The licensee's plan lacked the following required content: -Development of a policy/procedures for sewage and waste disposal; -Emergency officials' contact information to include the Office of Ombudsman for long term care (LTC); and -A means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy. On November 7, 2023, at 2:30 p.m. DM-C stated the licensee's EP plan lacked the required above components. MISSING RESIDENT PLAN/POLICY The licensee's undated, Missing Resident policy was included in the EP plan. The policy lacked evidence the assisted living director and clinical registered nurse reviewed or updated the policy and documented any changes, at least quarterly as required. On November 7, 2023, at 3:50 p.m. licensed assisted living director (LALD)-A stated the missing resident plan was last reviewed on May 29, 2023, during the annual EP plan review. LALD-A stated she was not aware the missing resident plan needed to be reviewed quarterly. The licensee's undated, Emergency and Disaster Preparedness policy included: 5. A written Communication Plan is complete that addresses the elements listed in 42 C.F.R. 483.73(c). 6. Our facility has developed and implements	0 680		

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0 680	Continued From page 14 emergency preparedness policies an procedures in compliance with 42 C.F.R. 483.73(c). 7. A written policy and procedure regarding missing residents is complete in compliance with MN Rule 4659.0110. 8. The facility will post the emergency disaster plan prominently. 11. The facility conducts exercises to test the emergency preparedness plan at least twice per year in compliance with 42 C.F.R. 483.73(d)(2). 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	0 730		

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0 730	Continued From page 15 assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R2). 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	0 730		

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0 730	Continued From page 16 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's record lacked a discharge summary to include: - diagnoses; - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. R2's diagnosis included hypertension (high blood pressure). R2's record contained a discharge progress note dated January 2, 2023, at 10:09 a.m. that indicated the resident was discharged to the attached skilled nursing facility for long term care. However, the summary lacked the above required content. On November 7, 2023, at 8:21 a.m. clinical nurse supervisor (CNS)-B stated a discharge summary had not been completed other than making an entry in the progress notes. CNS-B indicated she was not aware she needed to complete a discharge summary since he had not received medication management, and he had moved into the licensee's attached skilled nursing facility.	0 730		

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0 730	Continued From page 17 The licensee's undated, Discharge Summary policy noted a discharge summary would be written by the time of discharge. The discharge summary would include, if applicable: a. Summary of the resident's stay that including i. Diagnoses ii. Course of illnesses iii. Allergies iv. Treatments v. Therapies vi. Pertinent lab results vii. Pertinent radiology results viii. Pertinent consultation results ix. Final summary of the resident's status. The summary will be based upon the latest assessment or review and, if applicable, will include resident status including baseline and current mental, behavioral, and functional status. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (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	0 780		

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0 780	Continued From page 18 within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, 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 November 7, 2023, at 9:30 a.m., survey staff toured the facility with the director of maintenance (DM)-C. During the tour, survey staff observed the following:	0 780		

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0 780	Continued From page 19 1. Smoke alarms were not installed in the corridor outside each separate sleeping area. DM-C verified this deficient condition during the tour. 2. Smoke alarms were not provided in the sleeping rooms of resident apartments 101, 102, 103, 104, and 106. Smoke detectors were installed, but the presence of an audible device could not be verified during the tour. 3. In resident apartment 105, smoke alarms were not provided in the bedroom and outside the bedroom in the immediate vicinity. Smoke detectors were installed, but the presence of audible devices could not be verified during the tour. On November 13, 2023, at 3:28 p.m., survey staff emailed licensed assisted living director (LALD)-A requesting additional information on the fire alarm system installed at this facility. LALD-A responded to this email on November 14, 2023, at 1:45 p.m. LALD-A wrote no audible devices were installed inside the resident apartments that would sound an alarm if the smoke detectors were activated. On November 16, 2023, at 3:00 p.m., survey staff called LALD-A and explained the smoke alarm statute requirements. LALD-A stated they were not aware the currently installed fire alarm system did not meet the smoke alarm requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 20 (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 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 complete fire safety and evacuation training with residents and	0 810		

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0 810	Continued From page 21 employees. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 7, 2023, at 10:15 a.m., director of maintenance (DM)-C and licensed assisted living director (LALD)-A provided documenation on the licensee fire safety and evacuation plan, training and drills. Record review of the available documentation indicated the licensee did not have records to support fire safety and evacuation training had been completed with residents capable of assisting in their own evacuation at least once per year. Record review of the available documentation indicated the licensee did not have records to support employee training on the fire safety and evacuation plans had been completed within the last year. During interview on November 7, 2023, at 10:15 a.m., LALD-A stated the employee training frequency on these plans was upon hire and annually. LALD-A explained annual training had been completed but was not documented. LALD-A verified these deficient conditions and	0 810		

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0 810	Continued From page 22 explained they did not know the statute required employee training at least twice per year after hire. Regarding resident training, LALD-A verified this deficient condition and explained that residents were trained but this had not been documented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to	0 900		

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0 900	Continued From page 23 any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to execute a written contract with the required content for the individual(s) who resided in apartment 105 of the licensee's assisted living 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 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Minnesota Statute 144G.08 dated 2023, identified an "adult" is defined as a natural person who has attained the age of 18 years. An "assisted living contract" is defined as the legal agreement between a resident and an assisted living facility for housing and, if applicable, assisted living services. An "assisted living facility" is defined as a facility that provides sleeping accommodations and assisted living services to one or more adults. A "resident" is defined as an adult living in an assisted living facility who has executed an assisted living contract.	0 900		

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0 900	Continued From page 24 On November 7, 2023, at 10:00 a.m. during the engineer's tour of the facility with director of maintenance (DM)-C, room 105 was noted to have personal belongings inside including clothes hanging in the closet. DM-C identified room 105 as occupied by an employee. On November 7, 2023, at approximately 10:30 a.m. the surveyor noted mail outside room 105 addressed to unlicensed personnel (ULP)-F, a current employee. On November 7, 2023, at 2:30 p.m. DM-C stated there were two employees living in room 105. On November 7, 2023, at 3:56 p.m. licensed assisted living director (LALD)-A stated an assisted living contract was not executed for the individual(s) who resided in apartment 105. LALD-A stated current employees were living in the apartment and she was not aware they couldn't live there. LALD-A further stated, "only doing what my owner told me to do". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that	01060		

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01060	Continued From page 25 contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with	01060		

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01060	Continued From page 26 required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation 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 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: R3 was admitted on September 13, 2019. R3's diagnoses included congestive heart failure (heart muscle doesn't pump blood as well as it should) and atrial fibrillation (irregular and often rapid heart rhythm). R3's Service Plan dated September 25, 2023, indicated R3 received services including light housekeeping, laundry, whirlpool bathing and wound care three times per week. R3's progress notes dated October 13, 2023, at 3:31 p.m. indicated R3 had a change in mental status, was more lethargic, forgetful, had fallen twice in the last week without injury, had increased incontinence, and stated he had not been taking his medications the way he is supposed to for several days. The progress note identified R3 was transferred to the emergency room for evaluation. On November 6, 2023, at approximately 4:30	01060		

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01060	Continued From page 27 p.m. clinical nurse supervisor (CNS)-B stated R3 had not returned to the facility yet and his services were on hold. CNS-B indicated R3 had been transferred to a skilled nursing facility for rehabilitation following his hospitalization and would be returning following the stay. R3's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On November 7, 2023, at 9:15 a.m. CNS-B stated there was no written notice provided to R3, nor had the ombudsman been notified of R3's emergency relocation. CNS-B was unaware of requirement, indicating the licensee had not completed this for any residents requiring hospitalization.	01060		

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01060	Continued From page 28 The licensee's undated, Emergency Relocation Checklist, noted when a facility enacts an emergency relocation, the facility must deliver a written notice to the resident, their legal representative, and their designated representative (deliver written notice as soon as possible). Also send the notice to the resident's case manager if they are receiving home and community-based waiver funds. Deliver the notice to the Office of Ombudsman for Long Term Care as soon as possible and within 24 hours if the resident has relocated and not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=D	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	01290		

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01290	Continued From page 29 by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of one employee (licensed practical nurse (LPN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: LPN-D started employment on March 16, 2020. LPN-D's employee record contained a background study dated February 28, 2020, for a separate location operated by the licensee's owner; however, LPN-D's employee record lacked evidence the licensee affiliated a background study for their assisted living license. On November 7, 2023, at 4:00 p.m. licensed assisted living director (LALD)-A stated LPN-D's background study was submitted under a different license held by licensee and had not been affiliated with the assisted living license. The licensee's undated, Background Checks policy noted all employees must pass a background study and all contractor or volunteers with direct resident contact are required to have a background study. "Direct contact" means	01290		

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01290	Continued From page 30 providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human	01470		

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01470	Continued From page 31 Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one employee (licensed practical nurse (LPN-D) received orientation to assisted living facility licensing requirements and regulations before providing 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	01470		

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01470	Continued From page 32 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: LPN-D started employment on March 16, 2020. LPN-D's employee record lacked evidence of receiving orientation to assisted living to include the following required content: - overview of Assisted Living statues; - review of the provider's policies and procedures; - assisted living bill of rights; - handling of resident complaints, reporting of complaints, and where to report; - consumer advocacy services; - review of types of Assisted Living services the employees will provide and provider's scope of license; and - principles of person-centered planning/service delivery. On November 7, 2023, at 3:05 p.m. office manager (OM)-E stated LPN-D's file lacked the above required training. The licensee's undated, Assisted Living & Assisted Living with Memory Care Orientation-All Staff policy noted all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. At a minimum, orientation must include the following: a. an overview of Minnesota's assisted living	01470		

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01470	Continued From page 33 law; b. an introduction and review of agency policies and procedures related to the provision of assisted living services; e. the assisted living bill of rights and staff responsibilities to ensuring the exercise and protection of those rights; j. principles of person-centered planning and service delivery and how they apply to direct support services; k. types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and providers scope of licensure; and o. complaint process: -Handling resident complaints -The facility's system for receiving and responding to complaints, -Where and how to report complaints -Contact information for the Office of Health Facility Complaints -Contact information for the Office of the Ombudsman for long-term care -Contact information for the Office of the Ombudsman for Mental Health and Disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual	01500		

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01500	Continued From page 34 training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;	01500		

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01500	Continued From page 35 (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (licensed practical nurse (LPN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: LPN-D started employment on March 16, 2020. LPN-D's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: -assisted living bill of rights; -review of the facility's policies and procedures; and	01500		

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01500	Continued From page 36 -principles of person-centered planning/service delivery. On November 7, 2023, at 3:05 p.m. office manager (OM)-E stated LPN-D's file lacked the above required annual training. The licensee's undated, Annual Training policy noted all assisted living employees will complete annual education on the following topics: b. assisted living bill or [sic] rights; g. review of policies and procedures relating to the provision of assisted living services and how to implement them; h. principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
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	01620		

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01620	Continued From page 37 and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days 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 Service Plan dated September 25, 2023, indicated R1 received services including medication administration, blood sugar checks, and light housekeeping. R1's last three assessments were requested. Assessments dated March 24, 2023, June 24, 2023, and September 25, 2023, were provided.	01620		

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01620	Continued From page 38 The June 24, 2023, assessment was 92 days from the last date of the assessment, exceeding 90 calendar days. In addition, the September 25, 2023, assessment was 93 days from the last date of the assessment, exceeding 90 calendar days. On November 7, 2023, at 8:00 a.m. clinical nurse supervisor (CNS)-B stated R1's assessments were conducted after the 90-day requirement. CNS-B stated she had been doing the assessments quarterly by the calendar and not counting the number of days apart. The licensee's undated, Initial and On-Going Nursing Assessment of Residents policy identified on-going assessments would not exceed 90-day from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and	01650		

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01650	Continued From page 39 (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan included the required content 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 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: R1's diagnoses included diabetes mellitus (affects how the body uses blood sugar), hypertension (high blood pressure), macular	01650		

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01650	Continued From page 40 degeneration (eye disorder with gradual central vision loss), and spinal stenosis (narrowing of the spinal canal). R1's Service Plan dated September 25, 2023, indicated R1 received services including medication administration, blood sugar checks, and light housekeeping. The service plan lacked: - the schedule and method of monitoring assessments of the resident; and - the methods of monitoring staff providing services; On November 7, 2023, at 3:43 p.m., licensed assisted living director (LALD)-A stated the service plan lacked the above required content. In addition, LALD-A stated the same format was utilized for all residents. The licensee's undated, Contents of Service Plans policy noted the service plan would include the schedule and methods of monitoring reviews or assessments of the resident and the schedule and method of monitoring staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30336	A. BUILDING: _____ B. WING _____	11/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSTRANDER ASSISTED LIVING	309 MINNESOTA STREET OSTRANDER, MN 55961

(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
01700	Continued From page 41 section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 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 assessment to include all required content for one of one resident (R1) prior to providing 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	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30336	A. BUILDING: _____ B. WING _____	11/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSTRANDER ASSISTED LIVING	309 MINNESOTA STREET OSTRANDER, MN 55961

(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
01700	Continued From page 42 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 November 6, 2023, at 11:45 a.m. clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents. R1's diagnoses included diabetes mellitus (affects how the body uses blood sugar), hypertension (high blood pressure), macular degeneration (eye disorder with gradual central vision loss), and spinal stenosis (narrowing of the spinal canal). R1's Service Plan dated September 25, 2023, indicated R1 received services including medication administration, blood sugar checks, and light housekeeping. R1's prescriber orders dated June 27, 2023, included two for blood pressure, one for gout (form of inflammatory arthritis), two for diabetes, one for cholesterol, one for enlarged prostate, two for constipation, and one supplement. On November 7, 2023, at 7:32 a.m. licensed practical nurse (LPN)-D was observed to administer medications to R1. R1's Medication Review Form and Assessment of Need for Medication Management Services dated September 25, 2023, included an Order Summary Report which included the medication name, dosage, route, frequency, and indication. However, R1's record lacked evidence the RN	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30336	A. BUILDING: _____ B. WING _____	11/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSTRANDER ASSISTED LIVING	309 MINNESOTA STREET OSTRANDER, MN 55961

(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
01700	Continued From page 43 conducted a review of all medications the resident was known to be taking to include allergic or adverse reactions and actions to address these issues. In addition, R1's record did not identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications. On November 7, 2023, at 4:15 p.m. clinical nurse supervisor (CNS)-B stated R1's record lacked a medication management assessment to include all the required content as noted above prior to R1 receiving medication management services. The licensee's undated, Individualized Medication, Treatment & Therapy Management Plan policy noted the RN would develop a medication, treatment, and/or therapy management plan as appropriate based upon the resident assessment and the services provided. The policy did not identify the required components of the medication assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

MDH
EH-FPLS
18 Wood Lake Dr
Rochester
507-206-2700

Type: Full
Date: *11/07/23*
Time: 10:56:51
Report: 1045231063

Food and Beverage Establishment Inspection Report

Location:
Ostrander Assisted Living
309 Minnesota Street
Ostrander, MN55961
Fillmore County, 23

Establishment Info:
ID #: 0037938
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5076572231
ID #:

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

No NEW orders were issued during this inspection.

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

The purpose of this inspection was to review food handling practices for the assisted living clients. Staff advised that the meals are prepared within the nursing home kitchen and delivered directly to patients room and/or patients eat meals within the nursing home cafeteria/commons area.

Upon further review, currently no product stored, served or consumed within the small satellite style kitchen.

Report provided to

Susan Kalis, RN
Nursing Evaluator | Health Regulation Division
State Evaluations Team | Assisted Living and Homecare

Type: Full
Date: *11/07/23*
Time: 10:56:51
Report: 1045231063
Ostrander Assisted Living

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the MDH inspection report number 1045231063 of 11/07/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Janice Howe
Administrator

Signed:_____
Nicole Hunger
Public Health Sanitarian
Rochester District Office
nicole.hunger@state.mn.us