Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

August 8, 2023

Licensee
Autumn Hills
2528 Park Avenue Northwest
Bemidji, MN 56601

RE: Conditional License Number 408814
Health Facility Identification Number (HFID) 30484
Project Number(s) SL30484015

Dear Licensee:

On July 24, 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 April 6, 2023. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license are removed effective August 8, 2023.

The Department of Health 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.

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 6, 2023 survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on April 6, 2023, found not corrected at the time of the July 24, 2023, follow-up survey and subject to a penalty assessment are as follows:

1880-Storage Of Medications-144g.71 Subd. 19 = $500.00

The details of the violations noted at the time of this follow-up survey completed on July 24, 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.

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

Also, at the time of this follow-up survey completed on July 24, 2023, we identified the following violation(s):

1470-Content Of Required Orientation-144g.63 Subd. 2

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.

DOCUMENTATION OF ACTION TO COMPLY

Per 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).

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 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 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.

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,

Lindsey L. Krueger

Lindsey L. Krueger, RN, BS, MA
Assistant Division Director

Minnesota Department of Health
Health Regulation Division

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30484	A. BUILDING: _____ B. WING _____	R 07/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST CARE FACILITIES DBA AUTUMN HIL	2528 PARK AVENUE NW 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 SL30484015-1 On July 24, 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 April 6, 2023. At the time of the survey, there were 23 residents: all of whom were receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and issued.	{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.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}		

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{0 480}	Continued From page 1 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}		
{0 900} SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract.	{0 900}		

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{0 900}	Continued From page 2 Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of two residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R6's diagnoses included diabetes and hypertension (HTN- high blood pressure). R6's service plan dated April 5, 2023, indicated services included assistance with bathing, grooming, dressing, medication administration, blood glucose monitoring, housekeeping, and laundry. R6's record lacked evidence the contract had been fully executed as the facility must: - 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; - the facility must offer the resident the opportunity to identify a designated representative; and	{0 900}		

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{0 900}	Continued From page 3 -the resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. On July 24, 2023, at 12:56 p.m., consultant registered nurse (CRN)-O stated a contract had not been completed for R6. The licensee's Signing an Assisted Living Contract policy dated July 21, 2022, indicated when a prospective resident decided to move into the facility the assisted living contract was reviewed with the resident/responsible person, sign two copies of the contract, give one copy to the resident/responsible person, and retain one copy for the resident record. No further information was provided.	{0 900}		
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;	01470		

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01470	Continued From page 4 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470		

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01470	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of two employees (unlicensed personnel (ULP)-L). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-L was hired on May 18, 2023, to provide direct care services under the assisted living license. On July 24, 2023, at 12:15 p.m., the surveyor observed ULP-L to conduct a blood glucose check on R3 and administered R3's scheduled afternoon insulin. ULP-L's employee orientation record did not include the following: - an overview of the 144 G statutes; and - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) On July 24, 2023, at 1:33 p.m., consultant registered nurse (CRN)-O reviewed ULP-L's employee record and on-line training transcript.	01470		

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01470	Continued From page 6 CRN-O stated ULP-L had not completed the assisted living orientation as required. The licensee's Orientation of Staff and Supervisors and Content dated July 21, 2022, noted all staff providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. The orientation must contain the following topics: - an overview of the appropriate Assisted Living Statutes and rules - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the MAARC No further information was provided. TIME PERIOD OF CORRECTION: Twenty-One (21) days.	01470		
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not	{01530}		

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{01530}	Continued From page 7 provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-L) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-L was hired on May 18, 2023, to provide direct care services under the assisted living license. On July 24, 2023, at 12:15 p.m. the surveyor observed ULP-L to conduct a blood glucose check on R3 and administered R3's scheduled	{01530}		

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{01530}	Continued From page 8 afternoon insulin. ULP-L's employee record indicated the employee had completed a total of 4.50 hours of dementia training. ULP-L's employee record lacked a total of eight hours of the required dementia training to be completed within 160 hours of the employee's start date. On July 24, 2023, at 1:31 p.m., ULP-L stated she worked full time at the facility. On July 24, 2023, at 1:37 p.m., consultant registered nurse (CRN)-O reviewed ULP-L's employee record and on-line training transcript. CRN-O stated ULP-L had only completed 4.5 hours of dementia care training and she should have completed eight hours as required. The licensee's Dementia Training policy dated July 21, 2022, indicated for assisted living facilities direct care employees would complete eight hours of initial training within 160 hours of the employment start date. No further information was provided.	{01530}		
{01550} SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and	{01550}		

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{01550}	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees that did not provide direct care, received at least four hours of initial training on dementia care within 160 working hours of the employment start date, for one of one employee (kitchen manager (KM)-N). 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 licensee provided services under an assisted living license. During the entrance conference on July 24, 2023, at 9:48 a.m., licensed assisted living director (LALD)-A stated all employees had been reassigned courses on the facility's on-line training curriculum as a new employee, and would meet the assisted living requirements. KM-N was hired on April 25, 2023, to provide dietary needs at the assisted living facility. KM-N's record lacked evidence of receiving any dementia training, therefore, lacked evidence of the four hours of initial training within 160 working hours as required. On July 24, 2023, at 12:44 p.m., consultant	{01550}		

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{01550}	Continued From page 10 registered nurse (CRN)-M stated KM-N's employee record did not contain any dementia training. On July 24, 2023, at 12:45 p.m., KM-N stated he worked full time at the facility and had not completed any dementia training. The licensee's Dementia Training policy dated July 21, 2022, indicated non-direct care staff will complete four hours of initial training within 160 hours of the employment start date. No further information was provided.	{01550}		
{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 one of one resident's (R5) medications were stored according to manufacturer's recommended temperatures and failed to ensure the medication refrigerators 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected	{01880}		

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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
{01880}	Continued From page 11 or has the potential to affect a large portion or all the residents). The findings include: On July 24, 2023, at 11:58 a.m., the surveyor reviewed the medication refrigerator in the locked medication room with licensed practical nurse (LPN)-J and unlicensed personnel (ULP)-L. ULP-L stated the current temperature of the refrigerator was 46 degrees Fahrenheit (F). ULP-L stated the medication refrigerator temperature was monitored daily and recorded electronically. The refrigerator contained the following: - 10 Bisacodyl 10 milligram (mg) suppositories for R5 - six unopened Lantus 100 units/milliliter (ml) insulin pens (a multiple dose pen shaped injector device for insulin administration) for R9 - nine unopened Novolog 100 units/ml insulin pens for R6 - one unopened Levemir 100 units/ml insulin pen for R6 - nine unopened Novolog 100 units/ml insulin pens for R3 - one unopened Lantus 100 units/ml insulin pen for R3 - three unopened Trulicity 1.5 mg/0.5 ml pens for R3 - 11 unopened Novolog 100 units/ml insulin pens for R10 - three unopened Trulicity pens for R10 - two unopened Semglee 100 units/ml insulin pens for R10 On July 24, 2023, at 12:02 p.m., LPN-J stated the Bisacodyl suppositories should be stored at room temperature and not in the refrigerator.	{01880}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30484	A. BUILDING: _____ B. WING _____	R 07/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST CARE FACILITIES DBA AUTUMN HIL	2528 PARK AVENUE NW BEMIDJI, MN 56601

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{01880}	Continued From page 12 The medication refrigerator temperature logs dated July 1, 2023, through July 24, 2023, indicated the temperature of the medication refrigerator had been recorded nine times out of the 24 opportunities. On July 24, 2023, at 12:07 p.m., the medication refrigerator temperature logs dated July 1, 2023, through July 24, 2023, were reviewed with consultant registered nurse (CRN)-M. CRN-M stated the temperatures of the medication refrigerator had not been recorded daily as required. The manufacturer's instructions for Bisacodyl suppository dated November 21, 2022, indicated the suppositories should be stored at room temperature 59 to 86 degrees F. The manufacturer's instructions for Lantus insulin pens dated May 2019, indicated unopened insulin pens should be stored in the refrigerator 36 to 46 degrees F. The manufacturer's instructions for Novolog insulin pens dated June 2021 indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Novolog to freeze. The manufacturer's instructions for Levemir insulin pens dated January 2019 indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). The manufacturer's instructions for Trulicity dated November 2022 indicated to store the unopened pens in the refrigerator at 36-46 degrees F. Do not freeze Trulicity.	{01880}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{01880}	Continued From page 13 The manufacturer's instructions for Semglee dated June 2020, indicated to store the unopened pens in the refrigerator at 36-46 degrees F. The licensee's Medication Storage policy dated July 21, 2022, noted medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided.	{01880}		

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

May 9, 2023

Licensee
Autumn Hills
2528 Park Avenue Northwest
Bemidji, MN 56601

RE: Conditional License Number 408814
Health Facility Identification Number (HFID) 30484
Project Number(s) SL30484015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 6, 2023, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **August 7, 2023**.

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

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.

MDH may assess fines based on the level and scope of the correction orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $21,000. **MDH is not imposing these fines against your license at this time.**

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required = $3,000.00
St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders = $3,000.00
St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements = $3,000.00
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring = $3,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration = $3,000.00
St - 0 - 1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy = $3,000.00
St - 0 - 2320 - 144g.91 Subd. 4 (b) - Appropriate Care And Services = $3,000.00

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. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes Chapter 144G.**

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

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

b. **No new admissions:** Autumn Hills will not admit any new residents under its conditional assisted living facility license until MDH removes the "no new admissions" condition. Autumn Hills must provide MDH:

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

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

c. **Consultant:** Autumn Hills will contract with an RN to provide consultation concerning all resident(s) to whom Autumn Hills provides licensed assisted living services under the conditional license. <u>The consultant must have access to all resident(s) receiving services from Autumn Hills. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH</u>. The RN must not have any affiliation with Autumn Hills and MDH must review the RN's credentials and approve the selection. Autumn Hills is responsible for the expense of the contract with the RN. The main

purpose of the consultant is to provide guidance to Autumn Hills in an effort to help Autumn Hills align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Autumn Hills will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Autumn Hills and the RN consultant about a change. Each report will be electronically submitted to Jessica Chenze, Supervisor, State Evaluation Team, Health Regulation Division, at jessica.chenze@state.mn.us. Jessica Chenze can be reached at 218-332-5175 (office) with questions about reports. The content of the reports will include information such as:

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

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

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

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

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Autumn Hills is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Autumn Hills is in substantial compliance on the follow up survey, MDH will remove the conditions from Autumn Hills's assisted living facility license, and Autumn Hills will correct violations identified during the survey to come into substantial compliance. If MDH determines Autumn Hills is not in substantial compliance, MDH may take additional enforcement action against Autumn Hills, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:

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

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

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

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

Sincerely,



Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30484	A. BUILDING: _____ B. WING _____	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HILLS	2528 PARK AVENUE NW BEMIDJI, MN 56601

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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: SL# 30484015 On April 3, 2023, through April 6, 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 27 active residents; all of whom were receiving services under the Assisted Living license. Immediate correction orders were identified on April 3, 2023 and April 4, 2023, issued for SL30484015, tag identification 0110, 0495, 1750, 1950, and 2320. As of April 6, 2023, at time of exit, the immediacy of correction orders 0110, 0495, 1750, 1950 and 2320 remained, and non-compliance remains at a scope and level of I for all five correction orders.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=I	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 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 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 April 3, 2023 at 12:50 p.m. On April 4, 2023, at approximately 2:30 p.m. the level of this order was increased to a level three violation, but remained at widespread scope, due to the following two additional level three immediate orders: 0495 and 2320, both issued at widespread scope. The time period to correct 0110 remains immediate. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	0 110		

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0 110	Continued From page 2 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 included: On April 3, 2022, at 10:20 a.m., licensed assisted living director (LALD)-A stated he was the LALD for the facility. Review of BELTSS license verification website on April 3, 2023, at 12:11 p.m., did not indicate LALD-A was an LALD. Confirmation was received from BELTSS on April 3, 2023, at 12:43 p.m., that LALD-A did not complete all requirements to obtain a license, and therefore was not licensed. No further information provided. TIME PERIOD FOR CORRECTION: Immediate As of survey exit on April 6, 2023, at 11:45 a.m., the immediacy of this order had not been removed.	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the	0 250		

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0 250	Continued From page 3 license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, 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	0 250		

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0 250	Continued From page 4 performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on 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 April 3, 2023, at 10:22 a.m., clinical nurse supervisor (CNS)-B stated she was not familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Provisional Application for Assisted Living License, section titled Official Verification of	0 250		

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0 250	Continued From page 5 Owner or Authorized Agent licensed assisted living director (LALD)-A, identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - 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	0 250		

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0 250	Continued From page 6 a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally 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.	0 250		

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0 250	Continued From page 7 - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page 18 was electronically signed by authorizing agent LALD-A on March 15, 2022. The licensee had an assisted living license reissued on March 31, 2023, with an expiration date of March 30, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies of employees; - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting ongoing resident evaluations and assessments of resident needs; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis; - medication management; - treatment and therapy management; - delegation of tasks by the registered nurses or licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks As a result of this survey, the following orders were issued 0110, 0250, 0340, 0430, 0470, 0480, 0485, 0490, 0495, 0510, 0580, 0620, 0640, 0650, 0660, 0680, 0700, 0730, 0810, 0900, 0910, 0920,	0 250		

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0 250	Continued From page 8 0930, 0940, 0950, 1060, 1290, 1370, 1380, 1420, 1440, 1460, 1500, 1530, 1550, 1560, 1620, 1640, 1730, 1750, 1760, 1770, 1790, 1820, 1830, 1880, 1890, 1910, 1940, 1950, 1970, 2310, 2320, 3000, 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		
0 340 SS=I	144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond	0 340		

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0 340	Continued From page 9 to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the immediate orders, tag identification 0110, 0495, 1750, 1950 and 2320, during a survey completed on April 6, 2023. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 6, 2023, the Minnesota Department of Health (MDH) completed a survey resulting in 54 correction orders issued which included immediate orders 0110, 0495, 1750, 1950 and 2320 issued on April 3, 2023 and April 4, 2023. On April 3, 2023, at 12:52 p.m., licensed assisted living director (LALD)-A was notified via email by MDH of immediate correction order for tag 0110. On April 3, 2023, at 4:38 p.m., LALD-A responded via email that he had scheduled to take his fingerprints on Wednesday and "let me know as to what next steps are needed from my side so I can satisfy this requirement."	0 340		

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0 340	Continued From page 10 On April 4, 2023, at 8:24 a.m., LALD-A was notified via email by MDH the immediacy would stay in place until LALD-A received a license or residency permit from Board of Executives for Long-Term Services (BELTSS) or someone with an active LALD license would assume responsibility for the facility for tag identification 0110. On April 4, 2023, at 2:32 p.m., LALD-A was notified via email by MDH of immediate correction orders for tags 0495 and 2320. On April 4, 2023, at 5:02 p.m., LALD-A was notified via email by MDH of immediate correction orders for tags 1750 and 1950. On April 5, 2023, at 1:52 p.m., LALD-A responded via email "I am working on the formal plan right now. I will be leaving for a bit to get fingerprinted but will be returning right after. That appt (appointment) is at 3pm [sic] and will call you when I return." On April 5, 2023, at 3:47 p.m., LALD-A submitted a proposed plan via email for the immediate correction orders for tags 0495, 1750, 1950 and 2320. On April 5, 2023, at 4:25 p.m., LALD-A was notified via email by MDH the immediacy of correction orders for tags 0495, 1750, 1950 and 2320 would stay in place as the information provided was insufficient and did not include involvement from the registered nurse (RN) for the clinical based tags. On April 6, 2023, at 11:45 a.m., the immediacy of the five immediate orders identified remained as	0 340		

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0 340	Continued From page 11 the survey was exited. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a copy of the uniform disclosure of assisted living services and amenities (UDALSA) with the required content for three of three residents (R2, R3, R6).	0 430		

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0 430	Continued From page 12 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: R2 R2's diagnoses included diverticulitis, constipation and traumatic brain injury. R2's service plan dated, September 26, 2022, indicated services included assistance with bathing, grooming, dressing, transfers, colostomy care, behavior management, medication administration, housekeeping and laundry. On April 4, 2023, at 7:40 a.m., the evaluator observed unlicensed personnel (ULP)-E provide colostomy care for R2. R3 R3's diagnoses included history of myocardial infarction (heart attack), diabetes, hypertension (high blood pressure) and osteoarthritis. R3's service plan, dated September 23, 2022, indicated services included assistance with bathing, grooming, dressing, toileting, blood glucose, medication administration, housekeeping and laundry. On April 4, 2023, at 7:26 a.m., the evaluator observed ULP-D complete a blood glucose check and administer insulin to R3.	0 430		

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0 430	Continued From page 13 R6 R6's diagnoses included diabetes, hypertension and peripheral neuropathy (nerve damage). R6's service plan, dated March 22, 2023, indicated services included assistance with bathing, grooming, dressing, blood glucose, medication administration, housekeeping and laundry. On April 4, 2023, at 7:54 a.m., the evaluator observed ULP-D scan R6's Freestyle Libre (device that measures blood glucose levels). Review of R2, R3 and R6's records lacked evidence of a UDALSA to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. On April 5, 2023, at 10:53 a.m., licensed assisted living director (LALD)-A stated they have not provided the UDALSA to any resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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

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0 470	Continued From page 15 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 license. The facility was licensed for a capacity of 31 and had a current census of 27 residents. During the entrance conference on April 3, 2023, at 10:48 a.m., clinical nurse supervisor (CNS)-B stated she was the only registered nurse (RN) for the facility. CNS-B stated the usual staffing scheduled for the facility was as follows: - the RN was on site Monday through Thursday for eight hours - the day shift was staffed with four unlicensed personnel (ULP) from 7:00 a.m. to 3:00 p.m. - the evening shift was staffed with three to four ULPs from 3:00 p.m. to 11:00 p.m. - the night shift was staffed with two ULPs from 11:00 p.m. to 7:00 a.m. On April 5, 2023, at 4:02 p.m., the evaluator reviewed the staffing plan provided with CNS-B. CNS-B stated she had never seen this staffing plan form and the form was not filled out. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents:	0 480		

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0 480	Continued From page 16 (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included documents titled, Food and Beverage Establishment Inspection Report dated April 3, 2023 and April 6, 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	0 485		

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0 485	Continued From page 17 facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; 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: During the entrance conference on April 3, 2023, at 10:28 a.m., clinical nurse supervisor (CNS)-B stated all meals are prepared in this facility. On April 3, 2023, at 1:39 p.m., during the facility tour with CNS-B, the evaluator did not observe a posted weekly menu. CNS-B stated they do not post a menu one week in advance for the residents. On April 5, 2023, at 7:35 a.m., R3 stated a weekly	0 485		

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0 485	Continued From page 18 menu was not posted and she was not provided with a menu one week in advance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to	0 490		

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0 490	Continued From page 19 affect all 27 residents 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: During the entrance conference on April 3, 2023, at 10:31 a.m., clinical nurse supervisor (CNS)-B stated they offer residents to play bingo on Wednesdays and have a service dog come in one time per month. On April 3, 2023, the evaluator did not observe any planned or offered activities. Some residents remained in their room most of the day or were observed in the seating area of the commons room. On April 4, 2023, at 9:28 a.m., unlicensed personnel (ULP)-D stated the facility only offers bingo on Wednesdays and do not provide any other social or recreational activities. On April 5, 2023, at 4:02 p.m., CNS-B stated she was not aware of the regulation for the facility to offer a daily social or recreational activity. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 490		

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0 495	Continued From page 20	0 495		
0 495 SS=I	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse was available 24 hours a day, seven days a week to provide consultation to staff performing delegated nursing tasks and services. This had the potential to affect all residents, staff and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate correction order on April 4, 2023, at approximately 2:30 p.m. The findings include: On April 3, 2023, at 10:46 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B confirmed the on-call nurse schedule posted in the medication room and office was the schedule staff used when they needed to contact the nurse. On April 4, 2023, at 6:32 a.m., the evaluator observed the April staff schedule posting with unlicensed personnel (ULP)-H in the medication room. ULP-H stated the current staff schedule	0 495		

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	30484	A. BUILDING: _____ B. WING _____	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HILLS	2528 PARK AVENUE NW BEMIDJI, MN 56601

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0 495	Continued From page 21 does not list whom was on-call but previously the schedule did. ULP-H stated CNS-B and ULP-F rotated on-call every other week. The January 2023 staff schedule indicated that ULP-F was on-call 12 out of 31 days leaving the facility without a registered nurse (RN) readily available. On April 4, 2022, at 10:51 a.m., CNS-B confirmed ULP-F did do on-call every other week. CNS-B stated that she did not answer her phone when not on-call and ULP-F was not a licensed staff. On April 4, 2023, at 12:40 p.m., ULP-D stated ULP-F and CNS-B rotated call for the facility. ULP-D stated ULP-F was always on-call the weekend she was scheduled to work. The facility's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) dated January 28, 2023, indicated licensed staff were on site 24/7. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate As of survey exit on April 6, 2023, at 11:45 a.m., the immediacy of this order had not been removed.	0 495		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be	0 510		

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0 510	Continued From page 22 consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for three of three unlicensed personnel ((ULP)-I, ULP-D, ULP-E) during medication administration and treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-I On April 4, 2023, at 7:05 a.m., the evaluator observed ULP-I enter R4's room and donned gloves. ULP-I used a wet soapy washcloth to provide cleanse to R4's wound. ULP-I dried the wound with a dry washcloth and placed both washcloths on R4's table. ULP-I applied a topical ointment to R4's wound, doffed gloves, picked up the two wash clothes with bare hands and placed them in R4's bathroom. The evaluator did not observe ULP-I complete hand hygiene before or after donning and doffing gloves. ULP-I	0 510		

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0 510	Continued From page 23 proceeded to assist R4 with dressing, left R4's room and used hand sanitizer in the hallway. On April 4, 2023, at 7:09 a.m., ULP-I stated she normally would complete hand hygiene before and after entering a resident room. ULP-D On April 4, 2023, at 7:11 a.m., the evaluator observed ULP-D log into the electronic record and start the medication administration process for R8. ULP-D did not complete hand hygiene prior to preparing R8's scheduled oral medication. At 7:19 a.m., the evaluator observed ULP-D administer R8's scheduled morning medications and return to the electronic record and document R8's medications as administered. The evaluator did not observe ULP-D perform hand hygiene and proceeded to follow the same medication administration process for another resident. On April 4, at 7:26 a.m., ULP-D stated she usually washed her hands or used hand sanitizer before and after medication administration. ULP-D stated she did not wash her hands or use hand sanitizer before or after R8's medication administration and did not complete hand hygiene prior to another resident's medication administration. ULP-E On April 4, 2023, at 7:40 a.m., the evaluator observed ULP-E enter R2's room, donned gloves and removed R2's colostomy pouch. ULP-E cleansed R2's stoma with cleanser foam and wet wipes. ULP-E placed a new colostomy pouch on and doffed gloves. ULP-E bagged up R2's garbage and took it outside to the dumpster. Upon re-entering the building ULP-E went to the bathroom and washed her hands.	0 510		

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0 510	Continued From page 24 On April 4, 2023, at 7:50 a.m., ULP-E stated she did not perform hand hygiene before or after donning gloves and she normally "tried to handwash before and after each resident." On April 4, 2023, at 10:46 a.m., clinical nurse supervisor (CNS)-B stated the expectation of staff to complete hand hygiene should be upon entering or exiting a resident room and with donning or doffing gloves. The licensee's Hand Washing policy dated July 21, 2022, indicated hand washing will be performed by all employees between resident tasks and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.	0 580		

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0 580	Continued From page 25 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all 27 residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 3, 2023, at 10:57 a.m., the evaluator asked licensed assisted living director (LALD)-A for the documentation of the licensee's quality management activities. LALD-A stated the facility did not have a current ongoing quality management activity and would not be able to provide documentation. A policy was requested, however, not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 620 SS=F	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 26 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R8) who had incidents of elopement; and the licensee failed to fully develop a written policy and procedure for reporting cases of suspected maltreatment of vulnerable adults. 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 April 3, 2023, at 11:02 a.m., the evaluator asked clinical nurse supervisor (CNS)-B to provide the MAARC and incident reports for the last six months. The Incident Summary log dated October 1, 2022, through April 3, 2023, indicated R8 had two elopement incidents: one on October 1, 2022, at 2:10 p.m., and one on March 29, 2023, at 6:00 p.m. No MAARC reports were provided.	0 620		

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0 620	Continued From page 27 R8's diagnoses included dementia, hypertension, and shortness of breath. R8's service plan dated October 5, 2022, indicated the resident received services to include behavior management, medication administration, safety checks, housekeeping, laundry and assistance with dressing and bathing. On April 4, 2023, at 7:11 a.m., the evaluator observed unlicensed personnel (ULP)-D provide medication administration for R8. R8's assessments completed by CNS-B and dated November 25, 2022, and February, 28, 2023, indicated R8 was independent with mobility; was difficult to understand as she changes one topic to another quickly; R8 was at risk for elopement/wandering; R8 had a history of walking away from her home without informing her daughter; R8 also was identified as having disrobing behavior as R8 had been found several times in public areas without some clothing on; R8 was disorientated from reality; had severe cognitive impairment; and was a moderate fall risk. In addition, R8 had been identified as having patterns of wandering and noted R8 wanders inside the residence common areas but does not leave the building. R8 was identified as having wandering behavior with interventions that included: hourly checks and attempting to get a wander guard (a monitoring device in which the resident wears a bracelet and when the resident approaches a monitored door the sensor alerts the caregiver). R8's individual abuse prevention plan (which was incorporated into R8's assessment) dated February 28, 2023, noted R8 was not at risk to be abused by others or was not at risk to abuse	0 620		

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0 620	Continued From page 28 other vulnerable adults. R8 was at risk to abuse herself and the specific measures to minimize this risk were to "monitor whereabouts. Supervise interaction with other resident as possible, every two-hour checks". R8's Elopement report dated October 1, 2022, at 2:10 p.m., noted R8 had activated the wander guard sensor twice and each time R8 had been redirected back in the building. A few minutes later the wander guard sensor went off again and staff were unable to find R8 in the facility or on the facility grounds. Staff went outside to look for R8 and found her at the gas station parking lot which was approximately three blocks away from the facility [which is next to a four-lane high traffic road]. The incident was reported to the facility manager and R8's daughter was notified. R8's record lacked documentation of a reassessment by the RN following this incident. No MAARC report was provided for this incident of elopement. R8's Elopement report dated March 29, 2023, at 6:00 p.m., [recorded temperature for this evening was 19 degrees Fahrenheit (F), with winds at 9.8 miles per hour, making the outdoor temperature feel like 9 degrees F] noted R8 had been brought back to the facility by two people that said they found R8 about nine blocks away from the facility and they were wondering if she lived at the facility. The staff were not aware R8 had exited the building. Staff notified the RN that R8 had left the building, and someone had brought her back. R8's record lacked documentation of a reassessment by the RN following this incident. No MAARC report was provided for this incident of elopement.	0 620		

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0 620	Continued From page 29 On April 3, 2023, at 3:29 p.m., CNS-B stated she considered R8 to be a "high" elopement risk. CNS-B stated an incident report should be completed and the RN should review all incident reports with any elopement. CNS-B stated, "this does not always get done". CNS-B stated then the incident report was then put into the resident's file. CNS-B reviewed R8's Elopement report dated October 1, 2022, and stated there was no follow up on the elopement incident or a reassessment completed by the RN following this incident. CNS-B reviewed R8's Elopement report dated March 29, 2023, and stated she had reviewed the incident on April 3, 2023, however, did not follow up on the elopement incident or complete a reassessment. CNS-B stated both of R8's elopement incidents were not reported to MAARC. CNS-B stated, "I didn't know what MAARC was". POLICY The licensee's undated Vulnerable Adults and Maltreatment-Communication, Prevention, and Reporting policy indicated all residents would be provided a copy of the Minnesota Bill of Rights for Home Care; staff would be provided training on maltreatment and the reporting requirements; the MAARC contact number; and that each client [resident] would have an individual abuse prevention plan developed. The policy did not include the definitions for a vulnerable adult, abuse, and neglect; the licensee's internal and external reporting procedure; and the timeline for reporting suspected cases of maltreatment, abuse, or neglect. On April 5, 2023, at 11:45 a.m., CNS-B reviewed the licensee's Vulnerable Adults and Maltreatment-Communication, Prevention, and	0 620		

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0 620	Continued From page 30 Reporting policy and stated the policy was not completely developed and did not include the above noted areas. CNS-B stated she thought reports should be made to MAARC within 24 hours. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
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 post required content to include the 911 emergency number in common areas. This had the potential to affect all 27 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 640		

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0 640	Continued From page 31 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 April 3, 2023, at 1:39 p.m., the evaluator completed the tour of the facility with clinical nurse supervisor (CNS)-B. The evaluator did not observe the 911 emergency number posted in common areas. CNS-B stated there was not any posting of the 911 emergency number and "I did not know that was part of the regulations". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=F	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	0 650		

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0 650	Continued From page 32 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 interview and record review, the licensee failed to ensure employee records contained the required content for four of four employees (unlicensed personnel (ULP)-E, maintenance/kitchen (M/K)-C, ULP-F, clinical nurse supervisor (CNS)-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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-E ULP-E was hired November 20, 2022, to provide assisted living services. On April 5, 2023, at 12:05 p.m., CNS-B stated she was unable to locate a record for ULP-E. On April 5, 2023, at 3:41 p.m., licensed assisted living director (LALD)-A stated ULP-E did not have an employee record.	0 650		

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0 650	Continued From page 33 ULP-E's record lacked a job description and background study. M/K-C M/K-C was hired on December 1, 2020, to provide dietary and maintenance needs at the assisted living facility. On April 5, 2023, at 8:16 a.m., CNS- B stated M/K-C did not have an employee record. M/K-C's record lacked a job description and background study. ULP-F ULP-F had a start date of May 11, 2020, and began providing assisted living services on August 1, 2021. ULP-F's employee record included a previous performance evaluation that had been conducted on June 11, 2021. ULP-F's employee record did not include an annual performance review for 2022, which identified areas of improvement and training needs. On April 5, 2023, at 1:17 p.m., CNS-B stated ULP-F's last performance review had been completed in 2021. CNS-B stated "I don't have a performance review for 2022" for ULP-F. CNS-B CNS-B was hired July 1, 2022, to provide assisted living services. CNS-B's employee record lacked a background study and an authenticated job description.	0 650		

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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
0 650	Continued From page 34 On April 5, 2023, at 9:25 a.m., CNS-B stated she was unable to locate her background study clearance and the job description was not signed due to LALD-A printing it yesterday (April 4, 2023). The licensee's undated Employee File policy noted the employee file would contain the following: - background study - a current job description - documentation of an annual performance review, which identify areas of improvement and training recommendations No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity 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.	0 660		

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0 660	Continued From page 35 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a facility risk assessment and implementation of a TB infection control plan. In addition, the licensee failed to complete a two-step TST (tuberculin skin test) or other evidence of a TB screening such as a blood test for three of four employees (unlicensed personnel (ULP)E, ULP-F, maintenance/kitchen (M/K)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). TB RISK ASSESSMENT On April 3, 2023, at 10:54 a.m., during the entrance conference, the evaluator asked for the facility's TB risk assessment. TB INFECTION CONTROL PLAN The licensee lacked a written TB infection control plan to include: - identification of supervisory responsibilities for the TB infection control program -written TB risk assessment On April 3, 2023, at 2:25 p.m., clinical nurse supervisor (CNS)-B stated she is unable to locate	0 660		

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0 660	Continued From page 36 the TB risk assessment and "I have never completed one". TB SCREENING ULP-E ULP-E was hired on November 20, 2022, to provide direct care services to the facility's residents. ULP-E's record lacked a baseline TB screening and evidence of a two-step TST or TB blood test. On April 5, 2023, at 3:41 p.m., licensed assisted living director (LALD)-A stated ULP-E did not have record of a TST or baseline screening. ULP-F ULP-F was hired on May 11, 2020, to provide direct care services to the facility's residents. ULP-F's employee record included documentation of a baseline TB screening for active TB dated May 6, 2020, and a negative TST on January 18, 2021; however, a second step TST was not completed. On April 5, 2023, at 1:22 p.m., CNS-B stated ULP-F's second step TST had not been completed as required. M/K-C M/K-C was hired on December 1, 2020, to provide dietary and maintenance needs at the assisted living facility. M/K-C's record lacked a baseline TB screening and evidence of a two-step TST or TB blood test. On April 5, 2023, at 8:16 a.m., CNS-B stated M/K-C did not have record of a TST or baseline	0 660		

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0 660	Continued From page 37 screening. The licensee's Tuberculosis Screening policy dated July 21, 2022, indicated the following: -Identify an individual staff member responsible for the TB program -Maintain a current community TB risk assessment -Staff who work within the same air space of home care clients [sic] would be screened and tested for TB -New staff would have a blood test or two-step Mantoux conducted with results The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB risk assessment should be completed initially and then for low-risk settings the risk assessment should be updated every other year; each agency should have written TB infection control procedures. The MDH Tuberculosis Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TB skin test or a single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		

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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 observation, interview and record review, the licensee failed to develop and post 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	0 680		

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0 680	Continued From page 39 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 April 3, 2023, at 11:02 a.m., the evaluator asked for the licensee's EPP, which was provided and later reviewed by the evaluator. On April 3, 2023, at 1:39 p.m., the evaluator completed the facility tour with clinical nurse supervisor (CNS)-B. The evaluator did not observe signage posted or information regarding the licensee's EPP in the common areas of the facility. CNS-B confirmed ther was no signage posting of the EPP. The licensee's EPP provided to the evaluator included an Emergency Procedure binder with generic instructions for staff to follow in the case of a fire, flood, winter storm, bomb, and severe weather. The Emergency Procedure binder also included an outdated contact last of the leadership staff at the facility. The licensee's EPP provided did not include the following: - a completed hazard vulnerability assessment (HVA) - policies and procedures to address natural and man-made disasters - 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;	0 680		

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0 680	Continued From page 40 - 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 evacuated; - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - 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	0 680		

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0 680	Continued From page 41 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 April 5, 2023, at 9:00 a.m., the licensing assisted living director (LALD)-A stated he was not very familiar with appendix Z [a section of the Centers for Medicare and Medicaid Services state operations manual which includes the emergency preparedness guidelines]." After a brief review of the components required in an EPP by the evaluator, LALD-A stated he knew the EPP was "not complete". The licensee's undated Disaster Planning and Emergency Preparedness policy, noted the facility would have in place a general emergency preparedness plan, that was in alignment with the facility's requirement to also comply with the Centers for Medicare and Medicaid Services Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of	0 700		

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0 700	Continued From page 42 resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all 27 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: From April 3, 2023, through April 5, 2023, the evaluator had several observations of apartment door #28 shut, however not locked, or the door was left open. Apartment #28 was located adjacent of the resident dining room and living room commons area. On April 5, 2023, at 1:48 p.m., the evaluator entered the unlocked apartment #28 with licensed assisted living director (LALD)-A. The evaluator observed in apartment #28 two large totes with no lids placed along the wall. LALD-A stated the two totes contained current and past resident records and were stored in apartment #28 due to damage in the office, which was under construction, where the records were normally stored. On April 5, 2023, at 1:50 p.m., LALD-A stated any	0 700		

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0 700	Continued From page 43 resident, visitor or staff could enter apartment #28 anytime throughout the day, however LALD-A would normally lock the door every night. LALD-A stated resident records should be locked securely and accessed only by authorized staff of the licensee. The licensee's undated Client Record- Storage and Security policy indicated all client records will be stored and secured in an area where only authorized staff of the licensee will have access. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 700		
0 730 SS=F	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;	0 730		

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0 730	Continued From page 44 (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 730		

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0 730	Continued From page 45 or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Discharge Resident/Client Roster dated October 1, 2022, to April 3, 2023, indicated R1 was admitted on November 9, 2020, and was discharged on January 10, 2023. R1's diagnoses included cerebrovascular accident (stroke), hypertension (HTN-high blood pressure), obesity, bradycardia (slow heart rate) and hyperlipidemia (high cholesterol). R1's service plan dated September 26, 2022, indicated R1 received the following services: medication setup, housekeeping, laundry, and assistance with bathing. R1's discharge note, dated January 10, 2023, noted R1 had been discharged on January 7, 2023, to go home and live with family. R1's record lacked a discharge summary. On April 4, 2023, at 10:54 a.m., clinical nurse supervisor (CNS)-B stated a discharge summary had not been completed for R1 and a discharge summary would not be completed on any resident no longer at the facility. A policy was requested, however, not provided. No information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		

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0 810	Continued From page 46	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in 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	0 810		

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0 810	Continued From page 47 licensee failed to have fire safety and evacuation plans with the required elements, failed to conduct the required drills, and did not complete required training for residents and employees. These deficient practices 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on April 3, 2023, at approximately 12:30 p.m. with the Maintenance/Kitchen Manager (M/K)-C, on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Review of the available documentation indicated the licensee failed to maintain a Fire Safety and Evacuation Plan. Upon request for the Fire Safety and Evacuation Plan, none was provided. This deficient condition was verified by M/K-C. Review of the available documentation for the fire safety and evacuation plan indicated the licensee failed to describe the employees' actions to be taken in the event of a fire or similar emergency. Upon request, no documentation was provided. This deficient condition was verified by M/K-C. Review of the available documentation indicated	0 810		

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0 810	Continued From page 48 the licensee failed to provide fire safety and evacuation plans that showed 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. During interview, M/K-C was unable to provide documentation that identified resident needs or specific actions necessary during an evacuation. Although staff appeared knowledgeable to attend patient needs, no documentation was provided for procedures necessary in an evacuation. This deficient condition was verified by M/K-C. Review of the available documentation for fire safety and evacuation training indicated that employees failed to receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. During interview, M/K-C verified that training was not provided or documented for this deficient condition. Review of the available documentation for fire safety and evacuation training indicated the licensee failed to provide fire safety and evacuation plans that were always readily available within the facility. Upon request, no fire safety and evacuation plan documents were provided. This deficient condition was verified by M/K-C. Review of the available documentation for fire safety and evacuation training indicated that residents capable of assisting in their own evacuation did not receive training on the proper actions at least once per year. During interview, M/K-C verified that training was not provided or documented for this deficient condition. Review of the available documentation for fire	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30484	A. BUILDING: _____ B. WING _____	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HILLS	2528 PARK AVENUE NW 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 49 safety and evacuation drills indicated that evacuation drills were not performed twice per year per shift with at least one drill conducted every other month. During interview, M/K-C verified that drills were not performed or documented for this deficient condition. 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 900	Continued From page 50 any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of three residents (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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's diagnoses included diverticulitis, constipation, and traumatic brain injury. R2's service plan dated, September 26, 2022, indicated services included assistance with bathing, grooming, dressing, transfers, colostomy care, behavior management, medication administration, housekeeping, and laundry. On April 4, 2023, at 7:40 a.m., the evaluator observed unlicensed personnel (ULP)-E provide colostomy care for R2. R2's record lacked evidence the contract had been fully executed as the facility must: - give a complete copy of any signed contract and any addendums, and all supporting documents	0 900		

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0 900	Continued From page 51 and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated representative. On April 5, 2023, at 10:53 a.m., licensed assisted living director (LALD)-A stated a contract had not been completed for R2. The licensee's Signing an Assisted Living Contract dated July 21, 2022, indicated when a prospective resident decided to move into the facility the assisted living contract was reviewed with the resident/responsible person, sign two copies of the contract, give one copy to the resident/responsible person and retain one copy for the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the 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	0 910		

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0 910	Continued From page 52 (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R3, R6). 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: R3 R3's assisted living contract was signed April 8, 2022. R3's service plan, dated September 23, 2022, indicated services included assistance with bathing, grooming, dressing, toileting, blood glucose, medication administration, housekeeping, and laundry. On April 4, 2023, at 7:26 a.m., the evaluator observed unlicensed personnel (ULP)-D complete a blood glucose check and administer insulin to R3. R6 R6's assisted living contract was signed September 29, 2022. R6's service plan, dated March 22, 2023,	0 910		

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0 910	Continued From page 53 indicated services included assistance with bathing, grooming, dressing, blood glucose, medication administration, housekeeping, and laundry. On April 4, 2023, at 7:54 a.m., the evaluator observed ULP-D scan R6's Freestyle Libre (device that measures blood glucose levels). R3 and R6's assisted living contracts did not include current managing or authorized agent for the facility. On April 4, 2023, at 10:17 a.m., licensed assisted living director (LALD)-A stated the managing or authorized agent was not listed on the contract and the same contract was used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee;	0 920		

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0 920	Continued From page 54 (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 two of two residents (R3, R6). This had the potential to affect all 27 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: R3 R3's service plan, dated September 23, 2022, indicated services included assistance with bathing, grooming, dressing, toileting, blood glucose, medication administration, housekeeping, and laundry.	0 920		

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0 920	Continued From page 55 On April 4, 2023, at 7:26 a.m., the evaluator observed unlicensed personnel (ULP)-D complete a blood glucose check and administer insulin to R3. R6 R6's service plan, dated March 22, 2023, indicated services included assistance with bathing, grooming, dressing, blood glucose, medication administration, housekeeping, and laundry. On April 4, 2023, at 7:54 a.m., the evaluator observed ULP-D scan R6's Freestyle Libre (device that measures blood glucose levels). R3 and R6's [name of facility] assisted living contract dated April 8, 2022, and September 9, 2022, respectively, lacked a disclosure of the category of assisted living facility license held by the facility and, if the facility was not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living with dementia care license. On April 4, 2023, at 10:17 a.m., licensed assisted living director (LALD)-A stated the required contents identified above was missing and the same contract was used for all residents. No further information 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	0 930		

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0 930	Continued From page 56 residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R3, R6). This had the potential to affect all 27 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:	0 930		

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0 930	Continued From page 57 R3 R3's service plan, dated September 23, 2022, indicated services included assistance with bathing, grooming, dressing, toileting, blood glucose, medication administration, housekeeping, and laundry. On April 4, 2023, at 7:26 a.m., the evaluator observed unlicensed personnel (ULP)-D complete a blood glucose check and administer insulin to R3. R6 R6's service plan, dated March 22, 2023, indicated services included assistance with bathing, grooming, dressing, blood glucose, medication administration, housekeeping, and laundry. On April 4, 2023, at 7:54 a.m., the evaluator observed ULP-D scan R6's Freestyle Libre (device that measures blood glucose levels). R3 and R6's [name of facility] assisted living contract dated April 8, 2022, and September 9, 2022, respectively, lacked 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 was required for a transfer. In addition, the assisted living contract did not include contact information for the Ombudsman for Mental Health and Developmental Disabilities. On April 4, 2023, at 10:17 a.m., licensed assisted living director (LALD)-A stated the required contents identified above was missing and the same contract was used for all residents. No further information was provided.	0 930		

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0 930	Continued From page 58 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 care consulting services under section	0 940		

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0 940	Continued From page 59 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 execute a written assisted living contract with the required content for two of two residents (R3, R6). This had the potential to affect all 27 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: R3 R3's assisted living contract was signed April 8, 2022. R3's service plan, dated September 23, 2022, indicated services included assistance with bathing, grooming, dressing, toileting, blood glucose, medication administration, housekeeping, and laundry. On April 4, 2023, at 7:26 a.m., the evaluator observed unlicensed personnel (ULP)-D complete a blood glucose check and administer insulin to R3. R6 R6's assisted living contract was signed	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 60 September 29, 2022. R6's service plan, dated March 22, 2023, indicated services included assistance with bathing, grooming, dressing, blood glucose, medication administration, housekeeping, and laundry. On April 4, 2023, at 7:54 a.m., the evaluator observed ULP-D scan R6's Freestyle Libre (device that measures blood glucose levels). R3 and R6's Assisted Living contracts lacked the following required content: -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; and -the toll-free number for the Minnesota Adult Abuse Reporting Center (MAARC) On April 4, 2023, at 10:17 a.m., licensed assisted living director (LALD)-A stated the required contents identified above was missing and the same contract was used for all residents. 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	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 61 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 observation, interview and record review, the licensee failed to ensure two of two residents (R3, R6) 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 27 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	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 62 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: R3 R3's assisted living contract was signed April 8, 2022. R3's service plan, dated September 23, 2022, indicated services included assistance with bathing, grooming, dressing, toileting, blood glucose, medication administration, housekeeping, and laundry. On April 4, 2023, at 7:26 a.m., the evaluator observed unlicensed personnel (ULP)-D complete a blood glucose check and administer insulin to R3. R6 R6's assisted living contract was signed September 29, 2022. R6's service plan, dated March 22, 2023, indicated services included assistance with bathing, grooming, dressing, blood glucose, medication administration, housekeeping, and laundry. On April 4, 2023, at 7:54 a.m., the evaluator observed ULP-D scan R6's Freestyle Libre (device that measures blood glucose levels). R3 and R6's Assisted Living contracts lacked the following required content: -the right to name a designated representative with the required statutory language; and	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30484	A. BUILDING: _____ B. WING _____	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HILLS	2528 PARK AVENUE NW 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
0 950	Continued From page 63 -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. On April 4, 2023, at 10:17 a.m., licensed assisted living director (LALD)-A stated the required contents identified above was missing and the same contract was used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
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 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	01060		

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01060	Continued From page 64 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 observation, interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative: and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	01060		

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01060	Continued From page 65 of the residents). The findings include: The licensee's Current Resident Roster dated April 3, 2023, indicated R6 was admitted on September 5, 2022, to the assisted living facility. R6's service plan, dated March 22, 2023, indicated services included assistance with bathing, grooming, dressing, blood glucose, medication administration, housekeeping, and laundry. On April 4, 2023, at 7:54 a.m., the evaluator observed unlicensed personnel (ULP)-D scan R6's Freestyle Libre (device that measures blood glucose levels). R6's nurse notes included the following: -March 3, 2023, at 8:25 p.m., R6 was very hard to wake up and blood sugar was 62. Staff gave R6 orange juice, she drank maybe 3 sips and was very out of it. R6 had been sent to the emergency room around 6:30 p.m. -March 4, 2023, at 8:23 p.m., R6 was admitted to the hospital. -March 8, 2023, at 1:34 p.m., R6 would return to the assisted living facility around 3:30 p.m. R6'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 OOLTC; - 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	01060		

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01060	Continued From page 66 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, R6's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On April 5, 2023, at 1:04 p.m., clinical nurse supervisor (CNS)-B confirmed R6 was hospitalized March 3, 2023 through March 8, 2023. CNS-B stated she was not familiar with the emergency relocation regulations and "I (CNS-B) thought it was for if there was an emergency such as a fire". CNS-B stated the emergency relocation written notice, nor the OOLTC notification had not been completed for R6. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=C	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	01290		

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01290	Continued From page 67 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 current employee records contained all the required content to include a background study clearance letter with the correct affiliation for the assisted living facility for four of four employees (clinical nurse supervisor (CNS)-B, maintenance/kitchen (M/K)-C, unlicensed personnel (ULP)-D, ULP-E). 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). CNS-B CNS-B was hired July 1, 2022, to provide assisted living services. CNS-B's record lacked documentation of a cleared background study affiliated with the facility's license. MK-C M/K-C was hired on December 1, 2020, to provide dietary and maintenance needs at the assisted living facility.	01290		

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01290	Continued From page 68 M/K-C's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-D ULP-D was hired on October 26, 2020, and had begun providing assisted living services on August 1, 2022. On April 4, 2023, at 7:26 a.m., the evaluator observed ULP-D complete a blood glucose check and administer insulin to R3. ULP-D's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-E ULP-E was hired November 20, 2022, to provide assisted living services. On April 4, 2023, at 7:40 a.m., the evaluator observed ULP-E provide colostomy care for R2. ULP-E's record lacked documentation of a cleared background study affiliated with the facility's license. On April 5, 2023, at 8:26 a.m., licensed assisted living director (LALD)-A confirmed the employees identified above were currently employed by the facility. LALD-A stated the affiliation for the employee's background studies listed above were affiliated with the licensee's previous comprehensive license. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		

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01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health	01370		

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01370	Continued From page 70 technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel (ULP)-E to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-E was hired November 20, 2022, to provide assisted living services. On April 4, 2023, at 7:40 a.m., the evaluator observed ULP-E provide colostomy care for R2. ULP-E's employee record did not include documentation of training or competency for the following: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: haircare and bathing; care of teeth, gums and oral prosthetic	01370		

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01370	Continued From page 71 devices; care and use of hearing aids; and dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. On April 5, 2023, at 3:41 p.m., licensed assisted living director (LALD)-A stated ULP-E did not have an employee record. On April 5, 2023, at 4:20 p.m., clinical nurse supervisor (CNS)-B confirmed ULP-E did not have any record of training and stated, "I have not completed any training for ULPs since I have started (employment date July 1, 2022)". The licensee's undated Employee- New Staff Orientation policy indicated each new employee will be oriented in accordance with state regulations, will be assigned some educational reading and videos as required by the Minnesota Department of Health, and will be required to prove competency through written tests and returned demonstration.	01370		

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01370	Continued From page 72 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel (ULP)-E to include all required content. 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	01380		

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01380	Continued From page 73 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-E was hired November 20, 2022, to provide assisted living services. On April 4, 2023, at 7:40 a.m., the evaluator observed ULP-E provide colostomy care for R2. ULP-E's employee record did not include documentation of training and competency evaluations for the following topics: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; - range of motion and positioning; and -administering medications or treatments as required. On April 5, 2023, at 3:41 p.m., licensed assisted living director (LALD)-A stated ULP-E did not have an employee record. On April 5, 2023, at 4:20 p.m., clinical nurse supervisor (CNS)-B confirmed ULP-E did not have any record of training and stated, "I have not completed any training for ULPs since I have started (employment date July 1, 2022)".	01380		

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01380	Continued From page 74 The licensee's undated Employee- New Staff Orientation policy indicated each new employee will be oriented in accordance with state regulations, will be assigned some educational reading and videos as required by the Minnesota Department of Health, and will be required to prove competency through written tests and returned demonstration. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the	01420		

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01420	Continued From page 75 registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel (ULP-E) who provided colostomy care for 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-E was hired November 20, 2022, to provide assisted living services. R2's service plan dated, September 26, 2022, indicated services included assistance with colostomy three times per day. R2's Treatment Recap Summary dated March 1, 2023, through March 31, 2023, indicated staff were assisting with R2's colostomy three times per day. On April 4, 2023, at 7:40 a.m., the evaluator observed ULP-E provide colostomy care for R2. ULP-E's record lacked documentation to indicate ULP-E had received training and demonstrated competency for colostomy care. On April 5, 2023, at 4:20 p.m., clinical nurse supervisor (CNS)-B confirmed ULP-E did not have any record of training and stated, "I have not completed any training for ULPs since I have started (employment date July 1, 2022)".	01420		

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01420	Continued From page 76 The licensee's undated Employee- New Staff Orientation policy indicated each new employee will be oriented in accordance with state regulations, will be assigned some educational reading and videos as required by the Minnesota Department of Health, and will be required to prove competency through written tests and returned demonstration. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01440 SS=F	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	01440		

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01440	Continued From page 77 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)-E. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-E was hired November 20, 2022, to provide assisted living services. On April 4, 2023, at 7:40 a.m., the evaluator observed ULP-E provide colostomy care for R2. ULP-E's employee record lacked documentation of a registered nurse (RN) supervising ULP-E performing a delegated task within 30 days of beginning work with the licensee. On April 5, 2023, at 3:41 p.m., licensed assisted living director (LALD)-A stated ULP-E did not have an employee record. On April 5, 2023, at 4:20 p.m., clinical nurse	01440		

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01440	Continued From page 78 supervisor (CNS)-B confirmed ULP-E did not have any record of supervision and stated, "I have not completed any supervision for ULPs since I have started (employment date July 1, 2022)". A policy was requested, however, not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for three of three employees (clinical nurse supervisor (CNS)-B, maintenance/kitchen (M/K)-C, unlicensed personnel (ULP)-E). This has the potential to affect all 27 residents. This practice resulted in a level two violation (a violation that did not harm a client's health or	01460		

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01460	Continued From page 79 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: CNS-B CNS-B was hired July 1, 2022, to provide assisted living services. CNS-B's employee record lacked documentation to indicate the assisted living facility training requirements and regulations were completed. M/K-C M/K-C was hired on December 1, 2020, to provide dietary and maintenance needs at the assisted living facility. M/K-C's employee record lacked documentation to indicate the assisted living facility training requirements and regulations were completed. ULP-E ULP-E was hired November 20, 2022, to provide assisted living services. On April 4, 2023, at 7:40 a.m., the evaluator observed ULP-E provide colostomy care for R2. ULP-E's employee record lacked documentation to indicate the assisted living facility training requirements and regulations were completed. On April 5, 2023, at 9:26 a.m., CNS-B stated the licensee did not provide any training on	01460		

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01460	Continued From page 80 orientation to assisted living licensing requirements and regulations. CNS-B stated she did not recall receiving any training on orientation to assisted living when she had begun employment on July 1, 2022. The licensee's undated Employee File policy indicated employee files will contain record of orientation including required elements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
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 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;	01500		

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01500	Continued From page 81 (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; (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 an employee received all of the required annual training content for each 12 months of employment for one of one	01500		

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01500	Continued From page 82 employee (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 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 had a start date of May 11, 2020, and began providing assisted living services on August 1, 2021. ULP-F's employee record did not include the following required annual training: - training on reporting of maltreatment of vulnerable adults under section 626.557 - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - a review of infection control techniques and implementation of infection control standards including a review of hand washing techniques; the need for an 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 - review of the facility's policies and procedures related to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct	01500		

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01500	Continued From page 83 support services provided by the staff person On April 5, 2023, at 1:19 p.m., clinical nurse supervisor (CNS)-B stated she could not find any documentation of annual training for ULP-F. The licensee's undated Employee File policy indicated the employee record would have eight hours of annual home care training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be	01530		

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01530	Continued From page 84 available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-E) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS-B CNS-B was hired July 1, 2022, to provide assisted living services. CNS-B's employee record lacked a total of eight hours of the required dementia training was completed within 120 hours of the employee's start date. ULP-E ULP-E was hired November 20, 2022, to provide assisted living services. On April 4, 2023, at 7:40 a.m., the evaluator	01530		

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01530	Continued From page 85 observed ULP-E provide colostomy care for R2. ULP-E's employee record lacked a total of eight hours of the required dementia training was completed within 160 hours of the employee's start date. On April 5, 2023, at 9:26 a.m., CNS-B confirmed the above staff did not have any dementia training at the start of employment with the facility and both staff worked full time hours. CNS-B stated the licensee did not provide any training on dementia care. CNS-B stated she did not receive any training at the start of employment at the facility that she can recall when she had begun employment on July 1, 2022. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01550 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees that did not provide direct care, received at least four hours of	01550		

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01550	Continued From page 86 initial training on dementia care within 160 working hours of the employment start date, for one of one employee (maintenance/kitchen (M/K)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee provided services under an assisted living license. During the entrance conference on April 3, 2023, at 11:05 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided services to residents that had a diagnosis of dementia. M/K-C was hired on December 1, 2020, to provide dietary and maintenance needs at the assisted living facility. M/K-C's record lacked evidence of receiving any dementia training, therefore, lacked evidence of the four hours of initial training within 160 working hours, as required and lacked evidence of at least two hours of training on topics related to dementia care for each 12 months of employment thereafter. On April 5, 2023, at 9:26 a.m., CNS-B confirmed M/K-C's employee record lacked evidence of the required dementia care training and M/K-C had	01550		

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01550	Continued From page 87 worked more than 160 hours since employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01550		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training and the basic topics covered.	01560		

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01560	Continued From page 88 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 3, 2023, at 11:05 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided services to residents that had a diagnosis of dementia. The licensee lacked evidence of the dementia care training available in written or electronic form in the following areas: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -problem solving with challenging behaviors; -communication skills; and -person-centered planning and service delivery. On April 5, 2023, at 9:26 a.m., CNS-B stated the licensee did not provide any training on dementia care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01620 SS=I	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	01620		

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01620	Continued From page 89 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to conduct a comprehensive reassessment for one of one resident (R8) with a change of condition following incidents of elopement. Additionally, the RN failed to conduct an assessment every 90 days for one of three residents (R2). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems	01620		

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01620	Continued From page 90 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: R8 R8's diagnoses included dementia, hypertension, and shortness of breath. R8's service plan dated October 5, 2022, indicated the resident received services to include behavior management, medication administration, safety checks, housekeeping, laundry and assistance with dressing and bathing. On April 3, 2023, at 2:34 p.m., the evaluator observed R8 wandering out of her room and down the hallway towards the main entrance living room area. On April 3, 2023, at 2:46 p.m., the evaluator observed R8 wandering down the hallway towards the dining room area. R8's assessments completed by clinical nurse supervisor (CNS)-B and dated November 25, 2022, and February, 28, 2023, indicated R8 was independent with mobility; was difficult to understand as she changes the topic to another quickly; R8 was at risk for elopement/wandering; R8 had a history of walking away from her home without informing her daughter; R8 also was identified as having disrobing behavior as R8 had been found several times in public areas without some clothing on; R8 was disorientated from reality; had severe cognitive impairment; and was a moderate fall risk. In addition, R8 had been identified as having patterns of wandering and noted R8 wanders inside the residence common	01620		

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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
01620	Continued From page 91 areas but does not leave the building. R8 was identified as having wandering behavior with interventions that included: hourly checks and attempting to get a wander guard (a monitoring device in which the resident wears a bracelet and when the resident approaches a monitored door the sensor alerts the caregiver). R8's Elopement report dated October 1, 2022, at 2:10 p.m., noted R8 had activated the wander guard sensor twice and each time R8 had been redirected back in the building. A few minutes later the wander guard sensor went off again and staff were unable to find R8 in the facility or on the facility grounds. Staff went outside to look for R8 and found her at the gas station parking lot which was approximately three blocks away from the facility [which is next to a four-lane high traffic road]. The incident was reported to the facility manager and R8's daughter was notified. R8's record lacked documentation of a reassessment by the RN following this incident. R8's Elopement report dated March 29, 2023, at 6:00 p.m., [recorded temperature for this evening was 19 degrees Fahrenheit, with winds at 9.8 miles per hour, making the outdoor temperature feel like 9 degrees F] noted R8 had been brought back to the facility by two people that said they found R8 about nine blocks away from the facility and they were wondering if she lived at the facility. The staff were not aware R8 had exited the building. Staff notified the RN that R8 had left the building, and someone had brought her back. R8's record lacked documentation of a reassessment by the RN following this incident. R8's Behavior History dated March 1, 2023,	01620		

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01620	Continued From page 92 through April 5, 2023, included the following: - March 3, 2023, overnight - "wandering out of bed around midnight, redirected resident back to bed" - March 10, 2023, midday - "wondering [sic] into others rooms - March 17, 2023, PM - "individual went outside (using front door) x 2 this shift, setting off her call button, and was redirected by staff immediately to come back inside. Staff reminded individual of the cold temps and it not being safe for them to be outside alone" - March 19, 2023, AM - "wandering" - March 25, 2023, PM - "resident went out the door by the garden. She closed the door and came right back in and said it was cold. Staff told her that it's to [sic] cold to be going outside. Wandered around for a long time, didn't want to go to bed, kept getting up." - March 26, 2023, PM - "lots of wandering around the halls, had to be brought back to her room many times." - March 31, 2023, PM - "individual started walking out front door and call light alarmed staff. Staff quickly redirected individual back into the building, while explaining why it wasn't ok to be outside at that time and offered a different activity." - April 1, 2023, PM - "tried to leave at 3:30" - April 2, 2023, PM - "tried to elope at 4:00" On April 3, 2023, at 2:35 p.m., unlicensed personnel (ULP)-G stated R8 did wander and did try to get out of the building. ULP-G stated R8 had a wander guard so if she was to leave out the entrance door an alarm was sent to the ULP's pagers. ULP-G estimated R8 has had the wonder guard for about a year. On April 3, 2023, at 2:40 p.m. the evaluator	01620		

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01620	Continued From page 93 toured the facility with ULP-D and ULP-D pointed out all the exit doors. ULP-D stated all the doors except the main entrance door are locked on the outside, so if someone does get out; they cannot get back in. - the "garden door" exit was unlocked, and no alarm activated when the door was opened - "wing 2" exit door was unlocked, once the door opened it did alarm, however once the door was closed the alarm stopped. ULP-D stated if she was on the other end of the building, she would not be able to hear this door alarm go off. - "smoke area" exit door was unlocked, and no alarm activated when the door was opened - "old street entrance" exit door was unlocked and opened into a small foray which the outside door was locked. No alarm activated when the door was opened. - "main entrance" exit door was unlocked and had a wander guard sensor on the wall in the foray - "wing 1" exit door was unlocked, and alarm activated when the door was opened, however once the door was closed the alarm stopped. On April 3, 2023, at 3:29 p.m., CNS-B stated she considered R8 to be a "high" elopement risk. CNS-B stated an incident report should be completed and the RN should review all incident reports with any elopement. CNS-B stated, "this does not always get done". CNS-B stated the incident report was then put into the resident's file. CNS-B stated prior to R8's October 1, 2022 , elopement one hour safety checks were supposed to be done by the staff. CNS-B reviewed R8's Elopement report dated October 1, 2022, and stated there was no follow up on the elopement incident or a reassessment completed by the RN following this incident. CNS-B stated no new interventions were put into place to prevent R8 from eloping again. CNS-B reviewed	01620		

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01620	Continued From page 94 R8's Elopement report dated March 29, 2023, and stated she had reviewed the incident on April 3, 2023, however, did not follow up on the elopement incident or complete a reassessment, and did not put into place any new interventions to prevent R8 from eloping again. CNS-B confirmed the roads surrounding the facility were busy roads with lots of traffic. The evaluator asked for the documentation of R8's one hour safety checks for March 1, 2023, through April 3, 2023, however, they were not provided. R2 R2's diagnoses included diverticulitis, constipation, and traumatic brain injury. R2's service plan dated, September 26, 2022, indicated services included assistance with bathing, grooming, dressing, transfers, colostomy care, behavior management, medication administration, housekeeping, and laundry. On April 4, 2023, at 7:40 a.m., the evaluator observed ULP-E provide colostomy care for R2. R2's 90 day assessments were dated November 25, 2022, and February 28, 2023, respectively, for a total of 95 days in between assessments by the RN. On April 5, 2023, at 4:02 p.m., CNS-B confirmed the assessment dates listed above for R2 and stated assessments should be completed by the RN at least every 90 days. The licensee's Assessments, Reviews and Monitoring policy dated July 21, 2022, noted the initial nursing assessment or reassessment must	01620		

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01620	Continued From page 95 include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the RN who conducted the assessment. 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. The licensee's undated Missing Resident policy noted when the client is found, complete an incident report; update family and the police department; determine if alternate approaches to minimize the future risk of elopement are to be implemented, document in clients chart and in the communication book; the RN will update the Vulnerability Assessment and Abuse Prevention Plan, if appropriate; add additional interventions to Care Plan; provide written instructions to ULP; and educate all staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The	01640		

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01640	Continued From page 96 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 the service plan was revised to reflect the current frequency of services provided for one of three residents (R3) and failed to ensure the service plan included a resident or resident representative's signature and a licensee signature or other authentication by the licensee to document agreement on the services to be provided for one of three residents (R6). 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 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).	01640		

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01640	Continued From page 97 The findings include: SERVICE PLAN REVISION R3's diagnoses included history of myocardial infarction (heart attack), diabetes, hypertension (high blood pressure), and osteoarthritis. On April 4, 2023, at 7:26 a.m., the evaluator observed unlicensed personnel (ULP)-D complete a blood glucose check and administer insulin to R3. R3's prescriber orders dated January 13, 2023, included an order for oxygen to be applied via nasal cannula as needed to keep oxygen saturation levels above 90 percent as needed. R3's assessment dated January 17, 2023, indicated R3 refuses at times to wear her oxygen and does not need any special respiratory equipment. R3's service plan dated September 23, 2022, did not include oxygen therapy as needed. On April 5, 2023, at 4:13 p.m., clinical nurse supervisor (CNS)-B stated R3's service plan had not been revised to reflect the prescriber orders to provide oxygen therapy as needed. SERVICE PLAN AUTHENTICATION R6's service plan dated March 22, 2023, did not include a resident or resident representative signature and a licensee signature or other authentication by the licensee to document agreement on the services to be provided. On April 4, 2023, at 7:54 a.m., the evaluator observed ULP-D scan R6's Freestyle Libre (device that measures blood glucose levels).	01640		

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01640	Continued From page 98 On April 5, 2023, at 4:14 p.m., CNS-B confirmed R6's service plan did not include a signature by the licensee to authenticate the service plan agreement and did not include a resident or resident's representative signature. The licensee's undated Modification to the Service Plan indicated the service plan must be modified due to a change in the prescriber's orders and must be signed by the client or the client's responsible person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication 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	01730		

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01730	Continued From page 99 monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all required content for three of three residents (R2, R3, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01730		

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01730	Continued From page 100 The findings include: During the entrance conference on April 3, 2023, at 10:35 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. R2 R2's diagnoses included diverticulitis, constipation and traumatic brain injury. R2's service plan dated September 26, 2022, indicated the resident received medication management services which included medication administration three times daily. R2's after visit summary dated March 1, 2023, included but were not limited to the following medications: one mild pain reliever, one medication to maintain heart health, one medication to treat heartburn, one medication to treat infection, three medications to treat constipation, one medication to treat allergies, one medication to treat depression, and one medication to treat nerve pain. R3 R3's diagnoses included history of myocardial infarction (heart attack), diabetes, hypertension (high blood pressure) and osteoarthritis. R3's service plan dated September 23, 2022, indicated R3 received medication management services which included medication administration seven times daily. R3's prescriber orders dated January 13, 2023, included but were not limited to the following	01730		

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01730	Continued From page 101 medications: four medications to treat heart conditions, one medication to treat nerve pain, two mild pain relievers, three insulin medications, and one medication to treat acid reflux. On April 4, 2023, at 7:31 a.m., the evaluator observed unlicensed personnel (ULP)-D administer scheduled morning medication to R3. R6 R6's diagnoses included diabetes, hypertension and peripheral neuropathy (nerve damage). R6's service plan dated March 22, 2023, indicated R6 received medication management services which included medication administration seven times daily. R6's prescriber orders dated March 24, 2023, included but were not limited to the following medications: one mild pain reliever, three insulin medications, one medication for heart health, one medication to treat heart condition, one medication to treat thyroid, one severe pain reliever, and one medication to treat allergies. R2, R3 and R6's medication management plans dated March 16, 2023, January 17, 2023, and March 22, 2023, respectively, lacked documentation medication reconciliation had been completed or completed with new prescriber's orders. On April 5, 2023, at 4:05 p.m., CNS-B stated she does not complete medication reconciliation for any resident and was not aware of the full regulation for medication management. The licensee's Medication and Treatment Orders policy dated July 21, 2022, indicated the licensed	01730		

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01730	Continued From page 102 nurse would review all medications for progress, effectiveness and necessity on a regular basis or with resident change of condition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prior to delegating the nursing task of medication administration, the unlicensed personnel (ULP) demonstrated competency for administering medications. This had the potential to affect all 27 residents receiving assisted living services. 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	01750		

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01750	Continued From page 103 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). This practice resulted in an immediate correction order on April 4, 2023, at approximately 4:45 p.m. The findings include: On April 3, 2023, at 10:44 a.m., during entrance conference the clinical nurse supervisor (CNS)-B stated medication administration training and competency was done by other ULPs currently working the floor, including ULP-F and CNS-B helped with training sometimes as well. ULP-D was hired on October 26, 2020, to provide direct care services to residents of the assisted living facility. ULP-D's training record lacked evidence ULP-D completed training and demonstrated competency by the registered nurse (RN) in medication administration for all routes. On April 4, 2023, at 7:23 a.m., the evaluator observed ULP-D administer an as needed (PRN) medication of ibuprofen for R3. R6's March 2023 Medication Administration Record (MAR), indicated ULP-D administered R6's scheduled morning medication at 8:00 a.m. 11 out of 31 opportunities. On April 4, 2023, at 7:23 a.m., ULP-D stated she did not complete any medication administration training or competency with an RN. On April 4, 2023, at 2:38 p.m., CNS-B stated she	01750		

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01750	Continued From page 104 was unable to provide any documentation of medication administration training for ULP-D. The evaluator reviewed ULP-D's employee record with CNS-B and CNS-B was unable to locate any competency training for ULP in the facility's electronic record system. CNS-B stated she has not completed any medication administration training or competency for any ULP staff since she has been employed since July 1, 2022. The licensee's undated Medication Management-Medication Management Services Provided by Unlicensed Personnel indicated prior the ULP providing medication administration the RN must instruct the ULP and the ULP must demonstrate their competency back to the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate As of survey exit on April 6, 2023, at 11:45 a.m., the immediacy of this order had not been removed.	01750		
01760 SS=F	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	01760		

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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
01760	Continued From page 105 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 have medications readily available to administer as ordered for one of three residents (R7). In addition, the licensee failed to provide medication administration as ordered by the prescriber for two of three residents (R3, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: MEDICATION SUPPLY R7's diagnoses included hypertension (HTN-high blood pressure), chronic pain, depression, schizophrenia (a mental health condition in which people interpret reality abnormally which may result in a combination of hallucinations, delusions and extremely disordered thinking and behavior that impairs daily functioning), diabetes and asthma. R7's service plan dated October 2, 2022, indicated R7 received medication management services which included medication administration five times daily.	01760		

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	30484	A. BUILDING: _____ B. WING _____	04/06/2023

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01760	Continued From page 106 R7's assessment and Individualized Medication Management Plan dated January 9, 2023, noted the licensed nurse was responsible for monitoring medication supplies. The facility received medication in single dose punch cards monthly. Medications were kept in the locked medication cart and administered as the provider ordered by the trained unlicensed personnel (ULP) or nurse. On April 4, 2023, at 12:14 p.m., R7 stated she had not received her scheduled medications this morning because the medications had not been available for the ULP to administer. R7 stated ULP-F usually puts the medications in the "computer" but because ULP-F was not here today the registered nurse (RN) was supposed to do this and it didn't get done in time. On April 4, 2023, at 12:26 p.m., ULP-D stated she was assigned the medication cart today. ULP-D stated R7 and several other residents did not get their scheduled morning medications as ordered. ULP-D stated the facility received a medication delivery from the pharmacy at the beginning of each month. This delivery included a 30-day supply of medications packaged in blister packs (a transparent, molded piece of plastic often sealed to a sheet of cardboard, used to package tablets). ULP-D stated the medication blister packs needed to be checked before they were placed in the medication cart. ULP-D stated ULP-F was the person who usually did this but since she was not here today this responsibility landed on the clinical nurse supervisor (CNS)-B. ULP-D stated she had reminded CNS-B several times this needed to be done, however, the medications did not get in the medication cart until after 10:30 a.m. ULP-D stated per facility policy she only had a window of one hour before or one hour after a scheduled medication time to	01760		

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01760	Continued From page 107 administer the scheduled medication and by the time the 8:00 a.m. medications were placed in the cart it was well beyond the allowed one hour administration time and she was told to just skip the medications by CNS-B. ULP-D stated R7 did not receive the following 8:00 a.m. scheduled medications because they were not available for her to administer: - omeprazole 20 milligrams (mg) (medication to treat gastric reflux) - venlafaxine 75 mg ER (extended release) (antidepressant) - cyclobenzaprine 10 mg (muscle relaxant) - nitrofurantoin 100 mg (antibiotic) - bupropion 300 mg ER (antidepressant) - levothyroxine 50 mcg (micrograms) (hormone replacement) - lisinopril 5 mg (antihypertensive) - metformin 500 mg (anti-diabetic medication) - gabapentin 300 mg (anticonvulsant medication used to treat nerve pain) - Austedo 12 mg (used to treat involuntary movements) R7's Medication Administration Summary dated April 2023, indicated the above noted medications had not been given on April 4, 2023, at 8:00 a.m. as scheduled as the "meds [medications] not in the cart". R7's provider orders dated June 6, 2022, October 27, 2022, and December 2, 2022, included the following medications: - cyclobenzaprine 10 mg - bupropion 300 mg ER - levothyroxine 50 mcg - lisinopril 5 mg - metformin 500 mg - gabapentin 300 mg - Austedo 12 mg	01760		

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01760	Continued From page 108 R7's record lacked provider orders for the following medications omeprazole 20 mg, venlafaxine 75 mg ER, and nitrofurantoin 100 mg. On April 4, 2023, at 12:45 p.m., CNS-B stated she was aware there were "a lot" of residents who did not receive their scheduled 8:00 a.m. medications today as she had not unpacked and placed the medications delivered by pharmacy into the medication cart. CNS-B stated, "I guess I should have told [name of ULP] to give the medications late". MEDICATION ERROR R3 R3's diagnoses included history of myocardial infarction (heart attack), diabetes, hypertension (high blood pressure) and osteoarthritis. R3's service plan dated September 23, 2022, indicated R3 received medication management services which included medication administration seven times daily. R3's assessment and Individualized Medication Management Plan dated April 5, 2023, noted all medications were kept in the locked medication cart and administered as the doctor (prescriber) orders. On April 4, 2023, at 7:26 a.m., the evaluator observed ULP-D complete a blood glucose check and stated R3's blood glucose was 180 milligrams (mg)/deciliter (dL). ULP-D stated R3 was ordered to receive Novolog 15 units plus an additional 6 units from the sliding scale since her blood glucose reading was between 150 mg/dL to 200 mg/dL. ULP-D stated the sliding scale did not show on the electronic medication record (EMAR)	01760		

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01760	Continued From page 109 for the morning, however it should be as it was ordered by the physician. The evaluator observed ULP-D administer Novolog 21 units and documented Novolog 21 units given in the EMAR. R3's prescriber orders dated January 13, 2023, included Novolog 100 units/mL give 15 units subcutaneous (SQ) twice daily (breakfast and supper); 35 units SQ daily (lunch); Inject SQ per sliding scale with lunch and supper (150-199 mg/dL give 6 units, 200-249 mg/dL give 9 units, 250-299 mg/dL give 13 units, 300-349 mg/dL give 18 units, greater than 400 mg/dL give 20 units and notify nurse). From March 1, 2023, through April 3, 2023, R3's EMAR indicates more than Novolog 15 units was administered: -March 4, 2023, at 7:00 a.m., Novolog 21 units given -March 6, 2023, at 7:00 a.m., Novolog 21 units given -March 13, 2023, at 7:00 a.m., Novolog 21 units given -March 14, 2023, at 7:00 a.m., Novolog 21 units given -March 15, 2023, at 7:00 a.m., Novolog 21 units given -March 16, 2023, at 7:00 a.m., Novolog 21 units given -March 19, 2023, at 7:00 a.m., Novolog 21 units given -March 20, 2023, at 7:00 a.m., Novolog 21 units given -March 22, 2023, at 7:00 a.m., Novolog 21 units given -March 27, 2023, at 7:00 a.m., Novolog 21 units given -March 28, 2023, at 7:00 a.m., Novolog 21 units given	01760		

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01760	Continued From page 110 -March 29, 2023, at 7:00 a.m., Novolog 21 units given -April 2, 2023, 2023, at 7:00 a.m., Novolog 21 units given On April 5, 2023, at 3:28 p.m., CNS-B confirmed R3's morning Novolog order is 15 units to be given with no additional units. CNS-B stated she was unsure why ULPs use the sliding scale at breakfast time and ULP-F conducts the insulin training. R6 R6's diagnoses included diabetes, hypertension and peripheral neuropathy (nerve damage). R6's service plan dated March 22, 2023, indicated R6 received medication management services which included medication administration seven times daily. R6's assessment and Individualized Medication Management Plan dated April 5, 2023, noted R6 needs full medication management and medication administration. R6's prescriber orders dated March 24, 2023, included the following orders: -Collagenase 250 units/gram topical ointment applied to affected back of left heal -Latanoprost 0.005% ophthalmic solution instill one drop into each eye every night -loratadine 10 mg daily R6's EMAR from March 24, 2023, through April 3, 2023, did not include the above noted medications. On April 5, 2023, at 4:20 p.m., CNS-B stated the medications listed above have a prescriber order	01760		

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01760	Continued From page 111 and did not transcribe them into the EMAR. CNS-B stated R6 did not receive a discontinued order for Collagenase, Latanoprost or loratadine from March 24, 2023, through April 5, 2023. The licensee's undated Medication Administration-Documentation policy indicated medications will be administered per prescribers' orders. The licensee's Medication and Treatment Orders policy dated July 21, 2022, indicated the registered nurse is responsible for assuring current authorized prescriber orders for medication are kept on file in the resident's record and placed in the resident's medication administration record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R3).	01770		

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01770	Continued From page 112 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: During the entrance conference on April 3, 2023, at 10:35 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. R3's diagnoses included history of myocardial infarction (heart attack), diabetes, hypertension (high blood pressure) and osteoarthritis. R3's service plan dated September 23, 2022, indicated R3 received medication management services which included medication set up monthly by the registered nurse. R3's prescriber orders dated January 13, 2023, included orders for apixaban (for atrial fibrillation) 6 milligrams (mg) twice daily, gabapentin (for nerve pain) 300 mg every night, gabapentin 100 mg twice daily, lisinopril (for high blood pressure) 5 mg daily, Lipitor (for high cholesterol) 20 mg daily, carvedilol (for high blood pressure) 25 mg twice daily, furosemide (for edema) 40 mg daily, levothyroxine (for low thyroid levels) 50 micrograms (mcg) daily, omeprazole (for gastric reflux) 20 mg daily, spironolactone (for heart) 25 mg daily and vitamin D3 25 mcg daily. R3's records lacked documentation for	01770		

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01770	Continued From page 113 medication setup at the time of setup to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, route of administration and name of person completing medication setup. On April 3, 2023, at 1:13 p.m., the evaluator toured the facility with CNS-B, including a review of the locked medication room and assisted living medication cart. The evaluator observed in the medication cart 28 day preset blister packs (a transparent, molded piece of plastic, often sealed to a sheet of cardboard, used to package tablets) of the above noted medications for R3. Some of the blister packs had handwritten labels and others had a label taped to them that was provided by the pharmacy. On April 3, 2023, at 1:13 p.m., RN-A stated the medications in the blister packs noted above for R3 had been setup by unlicensed personnel (ULP)-F and herself. CNS-B stated the majority of the resident medications are set up in the preset blister packs by herself and ULP-F, in addition there was no place the medication set up was documented. The licensee's Medication Administration Weekly Dosage Box Set Up dated August 1, 2020, indicated the licensed nurse will set up medications weekly into the dosage boxes and upon completion will document the set up on the medication administration record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

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01790	Continued From page 114	01790		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in	01790		

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01790	Continued From page 115 the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. In addition, the licensee failed to ensure two of two ULPs (ULP-D, ULP-E) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01790		

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01790	Continued From page 116 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: UNPLANNED TIME AWAY POLICY AND PROCEDURE FOR ULP The licensee's Medication Management - Medication Administration - Planned and Unplanned Time Away policy dated August 1, 2021, indicated for unplanned client time away when a pharmacist or licensed nurse was not available, the RN may delegate this task to ULP if the RN has trained the ULP and determined the ULP to be competent to follow the procedures for giving medications to clients. The RN needs to develop written procedures for the ULP, including any special instructions or procedures regarding controlled substances that are prescribed for the client. The licensee's policy lacked the written procedure to include: - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; - how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident,	01790		

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01790	Continued From page 117 and other required information; - how the RN shall be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative; - a review by the RN of the completion of this task to verify that this task was completed accurately by the ULP; and - how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication On April 5, 2023, at 10:06 a.m., clinical nurse supervisor (CNS)-B stated the unplanned time away procedure had not been developed. TRAINING AND COMPETENCY EVALUATIONS ULP-D ULP-D was hired on October 26, 2020, and began providing assisted living services including medication administration on August 1, 2022. On April 4, 2023, at 7:31 a.m., the evaluator observed ULP-D administer scheduled morning medication to R3. ULP-E ULP-E was hired November 20, 2022, to provide assisted living services including medication administration. ULP-D and ULP-E's records lacked evidence to indicate ULP-D and ULP-E had been trained and had demonstrated competency to prepare and provide medications to residents for unplanned times away from home. On April 5, 2023, at 4:20 p.m., CNS-B confirmed	01790		

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01790	Continued From page 118 ULP-D and ULP-E did not have any record of unplanned time away training and stated, "I have not completed any training for ULPs since I have started (employment date July 1, 2022)". The licensee's Medication Administration-Planned and Unplanned Time Away policy dated August 1, 2021, indicated the RN can delegate unplanned time away if the RN has trained the ULP and determined the ULP is competent to follow the procedures for giving medication to clients. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of two residents (R7) 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	01820		

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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
01820	Continued From page 119 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: R7's diagnoses included hypertension (HTN-high blood pressure), chronic pain, depression, schizophrenia (a mental health condition in which people interpret reality abnormally which may result in a combination of hallucinations, delusions and extremely disordered thinking and behavior that impairs daily functioning), diabetes and asthma. R7's service plan dated October 2, 2022, indicated R7 received medication management services which included medication administration five times daily. R7's assessment and Individualized Medication Management Plan dated January 9, 2023, noted R7 received full medication management services and the staff received medication orders from the provider. R7's Medication Administration Summary dated March 1, 2023, through April 3, 2023, indicated the following scheduled medications had been administered: - omeprazole 20 milligrams (mg) (medication to treat gastric reflux) twice daily - venlafaxine 75 mg ER (extended release) (antidepressant) daily - nitrofurantoin 100 mg (antibiotic) daily R7's record lacked provider orders for the above noted medications.	01820		

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	30484	A. BUILDING: _____ B. WING _____	04/06/2023

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01820	Continued From page 120 On April 5, 2023, at 1:01 p.m., clinical nurse supervisor (CNS)-B stated she did not have provider orders for R7's omeprazole, venlafaxine, and nitrofurantoin. CNS-B confirmed these were medications were being administered by the staff. The licensee's Medication and Treatment Orders policy dated July 21, 2022, noted the registered nurse (RN) was responsible for assuring current, authorized prescriber orders for medications or treatments administered by the staff were kept on file in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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 interview and record review, the licensee failed to renew prescriptions at least every 12 months for one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a	01830		

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01830	Continued From page 121 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 April 3, 2023, at 10:35 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. R2's diagnoses included diverticulitis, constipation and traumatic brain injury. R2's service plan dated, September 26, 2022, indicated services included medication set up and medication administration three times daily. R2's medication administration record (MAR) dated March 1, 2023, through March 31, 2022, indicated the following medications were scheduled and administered: -aspirin (heart health) 81 milligrams (mg) daily -docusate sodium (constipation) 200 mg daily -loratadine (treat allergies) 10 mg daily -pregabalin (anticonvulsant) 150mg three times per day -sertraline (antidepressant) 50 mg daily -triamcinolone (skin irritation) 0.1% cream applied three times per day -acetaminophen (mild pain reliever) 500mg-1000 mg every 6 hours as needed R2's unauthenticated after visit summary dated March 1, 2023, included all of the above medications. On April 5, 2023, at 4:02 p.m., CNS-B stated she was unable to locate any signed annual orders for	01830		

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01830	Continued From page 122 R2 and was not aware medication prescriptions needed to be renewed at least annually. The licensee's Renewal of Medication and Treatment Orders policy dated July 21, 2022, indicated a medication order must be renewed at least every 12 months or more frequently if medications are new or changed. No further information was provided. TIME PERIOD FOR 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 prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access for one of one medication room. 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	01880		

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01880	Continued From page 123 a large portion or all of the residents). The findings include: During the entrance conference on April 3, 2023, at 10:35 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. On April 4, 2023, from 6:25 a.m. through 7:54 a.m., the evaluator had several observations of the medication room door open and not attended by staff. The evaluator also observed several residents walking past the unattended medication room during that time. Inside the medication room under the table were three large cardboard boxes containing resident medications that had not been placed into the locked medication cart. On April 4, 2023, at 7:54 a.m., unlicensed personnel (ULP)- D stated several resident's medication was in the cardboard boxes and ULP-F or CNS-B normally place them into the medication cart monthly. ULP-D confirmed the medication room door had been left open and left unattended leaving access to the resident medication available to any resident, staff, or visitor. On April 4, 2023, at 10:48 a.m., CNS-B stated the three large cardboard boxes in the medication room had resident medication in them and had not been transferred to the locked medication cart. CNS-B stated, "I don't do the med (medication) cart, but I suppose the door (medication room door) should be locked when no staff are present". The licensee's undated Storage of Medication	01880		

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01880	Continued From page 124 policy, indicated medications stored outside of a client's private "living space" [sic] must be in a secure [sic] and permit only authorized personnel to have access. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained with legible information including the expiration date for time sensitive medications for one of two residents (R3). In addition, the licensee failed to monitor for expired medications in the licensee's resident medications and stock medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	01890		

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01890	Continued From page 125 pervasive). The findings include: During the entrance conference on April 3, 2023, at 10:35 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. DATING TIME SENSATIVE MEDICATIONS On April 4, 2023, at 7:31 a.m., the evaluator observed unlicensed personnel (ULP)-D administer scheduled morning insulin to R3. R3's Novolog 100 units/milliliters (mL) pen (a multiple dose pen shaped injector device for insulin administration) had a label from the pharmacy to indicate when the insulin pen was opened, however, it was not filled in. April 4, 2023, at 7:26 a.m., ULP-D confirmed the pen was not labeled with the open date and was not sure when the pen was opened. April 4, 2023, at 10:47 a.m., CNS-B stated insulin pens come prelabeled with the expiration date listed, but staff should make sure the label is filled out when opening. CNS-B stated she was not familiar with the licensee's insulin policy. The manufacturer's instructions for Novolog insulin pens dated October 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. EXPIRED MEDICATIONS On April 3, 2023, at 1:16 p.m., the evaluator toured the facility with CNS-B including a review of the locked medication cart in the locked	01890		

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01890	Continued From page 126 medication room. CNS-B confirmed the following: -R2's Triamcinolone Acetonide cream 0.5% containing approximately half the tube left expired October 2022; and -unopened stock magnesium 250 milligram (mg) expired March 2023 On April 3, 2023, at 1:28 p.m., CNS-B stated, "I do not check for expired resident medication, but would assume the ULPs should check them frequently". The licensee's Disposal of Medication policy dated August 1, 2020, indicated any expired medication managed by the licensee would be disposed of according to the accepted practices of the Minnesota board of pharmacy and the labels from the containers would be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of	01910		

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01910	Continued From page 127 medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R1) upon discharge. 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 April 3, 2023, at 10:35 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. The licensee's Discharged Resident/Client Roster dated April 3, 2023, indicated R1 was admitted on November 9, 2020, and discharged on January 10, 2023, to return home with family.	01910		

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01910	Continued From page 128 R1's diagnoses included cerebrovascular accident (stroke), hypertension (HTN-high blood pressure), obesity, bradycardia (slow heart rate) and hyperlipidemia (high cholesterol). R1's service plan dated September 26, 2022, indicated R1 received medication administration services. R1's Medication Administration Record (MAR) for January 2023, indicated the resident received the following medications: -aspirin (heart health maintenance) 81 milligrams (mg) daily -Eliquis (prevent blood clots) 5 mg twice daily -gemfibrozil (treat high cholesterol) 600 mg twice daily -lisinopril (treat high blood pressure) 40 mg daily -loratadine (treat allergies) 10 mg daily -magnesium 500 mg three times per day -thiamin B-1 100 mg daily -atorvastatin (treat high cholesterol) 80 mg daily On April 4, 2023, at 10:54 a.m., clinical nurse supervisor (CNS)-B stated she had no physician medication orders for R1. R1's Nurses Note dated January 10, 2023, at 9:09 a.m., indicated R1 was discharged to home with family on Saturday (January 7, 2023) and all medications were sent with family. R1's record lacked documentation for the disposition of the above noted medications to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 129 On April 4, 2023, at 10:54 a.m., CNS-B stated a medication disposition had not been completed for R1 and medication disposition would not be completed on any resident no longer at the facility as she was not familiar with the licensee's policy. The licensee's Disposal of Medication policy dated August 1, 2020, indicated upon disposition, the licensee must document in the client's record the disposition of the medication including the name, strength, prescription number as applicable, quantity, date of disposition and other individuals involved in the disposition. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;	01940		

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01940	Continued From page 130 (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 two of four residents (R3, R4). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on April 3, 2023, at 10:40 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment services to residents.	01940		

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01940	Continued From page 131 R3 R3's diagnoses included history of myocardial infarction (heart attack), diabetes, hypertension (high blood pressure) and osteoarthritis. R3's prescriber orders dated January 13, 2023, included orders for oxygen to be applied via nasal cannula as needed to keep oxygen saturation levels above 90 percent as needed and to test blood glucose four times per day. R3's medication administration record (MAR) dated March 1, 2023, through March 31, 2023, indicated staff were to apply oxygen as needed for oxygen saturations less than 90 percent. R3's record lacked evidence ULP's were checking R3's oxygen saturation levels. R3's Blood Sugar Resident Overview dated March 1, 2023, through April 5, 2023, indicated staff were checking R3's blood sugar level three times per day. On April 4, 2023, at 7:26 a.m., the evaluator observed unlicensed personnel (ULP)-D complete a blood glucose check and administer insulin to R3. R3's service plan dated September 23, 2023, lacked a written statement of the treatment of services the resident received to include oxygen and to reflect blood glucose being checked four times daily. R3's record lacked evidence of an individualized treatment or therapy management plan which included the following: -a statement of services that would be provided; -identification of treatment or therapy tasks that will be delegated to ULPs; -procedures for notifying a registered nurse (RN) or appropriate licensed health professional when	01940		

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01940	Continued From page 132 a problem arises with treatments or therapy services; and -any resident-specific requirements related to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On April 5, 2023, at 4:13 p.m., CNS-B stated she was not aware R3 had an order for oxygen. CNS-B stated the oxygen was not listed on the service plan and the service plan was not revised to reflect blood glucose checks four times per day. CNS-B stated there was not an individualized treatment plan for oxygen or blood glucose checks for R3. R4 R4's diagnoses included pleural effusion (excess fluid around lungs), hypothyroidism and unspecified pressure ulcer (bed sore). R4's prescriber orders dated March 13, 2023, included an order for cleansing buttock wound with mild soap and water twice daily then apply Triad cream to open wounds and surrounding skin. R4's Resident Notes dated March 1, 2023, through April 5, 2023, indicated staff were providing wound care with no instructions and documenting "Done". On April 4, 2023, at 7:05 a.m., the evaluator observed ULP-I provide wound care for R4. R4's service plan dated September 26, 2022, lacked a written statement of the treatment services the resident received to include wound	01940		

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01940	Continued From page 133 care twice daily. R4's record lacked evidence of an individualized treatment or therapy management plan which included the following: - a statement of the type of services that would be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to ULPs; -procedures for notifying a RN or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements related to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On April 5, 2023, at 4:09 p.m., CNS-B confirmed R4's wound care was not listed on the service plan and R4's record lacked an individualized treatment plan for R4's wound. The licensee's Treatment and Therapy Management Plan policy dated July 21, 2022, indicated the facility would prepare and include in the service plan a written statement of the treatment or therapy services that would be provided to the resident. The facility would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: - a statement of the type of services that would be provided; -documentation of specific resident instructions relating to the treatments or therapy administration;	01940		

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01940	Continued From page 134 - identification of treatment or therapy tasks that will be delegated to ULP; -procedures for notifying a RN or appropriate health professional when a problem arises with treatment or therapy received; - any resident-specific requirements relating to documentation of treatment and therapy received; - verification that all treatment and therapy is 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=I	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;	01950		

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01950	Continued From page 135 (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prior to delegating the nursing task of blood glucose monitoring and changing the Freestyle Libre sensor, unlicensed personnel (ULP) demonstrated competency to perform the tasks or procedure to the registered nurse (RN) for one of one employee (ULP-D). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate correction order on April 4, 2023, at 4:45 p.m. The findings include: On April 3, 2023, at 10:44 a.m., during entrance conference the clinical nurse supervisor (CNS)-B stated medication administration training and competency was done by other ULPs currently working the floor, including ULP-F and CNS-B helped with training sometimes as well. ULP-D was hired on October 26, 2020, to provide direct care services to residents of the assisted living facility. ULP-D's training record lacked	01950		

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01950	Continued From page 136 evidence ULP-D completed training and demonstrated competency by the RN in blood glucose monitoring and using the Libre to scan for blood glucose levels. R6's Blood Glucose checks, dated March 14, 2023, through April 4, 2023, indicated R6's blood sugars should be checked three times per day using the Freestyle Libre. ULP-D completed 26 out of 66 opportunities of blood sugar checks for R6. On April 4, 2023, at 7:54 a.m., the evaluator observed ULP-D scan R6's Libre sensor. The report showed the sensor needed to be replaced and would not be able to give a blood glucose reading. ULP-D proceeded back to the medication room to retrieve a new Freestyle Libre sensor and then returned to R6's room. At 8:02 a.m., the evaluator observed ULP-D remove the Freestyle Libre sensor of R6's right arm and then ULP-D proceeded to place a new Freestyle Libre sensor on R6's left arm. ULP-D stated she was not trained by a RN and learned how to complete blood glucose checks and changing the sensor for the Freestyle Libre for her mother. On April 4, 2023, at 2:38 p.m., CNS-B stated she was unable to provide any documentation of training for ULP-D. The evaluator reviewed ULP-D's employee record with CNS-B and CNS-B was unable to locate any competency training for ULP in the facility's electronic record system. CNS-B stated she has not been trained to the Freestyle Libre and has not trained any ULPs for the blood glucose competency. A policy was requested, however not provided. No further information was provided.	01950		

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01950	Continued From page 137 TIME PERIOD FOR CORRECTION: Immediate As of survey exit on April 6, 2023, at 11:45 a.m., the immediacy of this order had not been removed.	01950		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or 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 interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of four residents (R3) who received treatments managed by the provider. 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: During the entrance conference on April 3, 2023,	01970		

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01970	Continued From page 138 at 10:40 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment services to residents. R3's diagnoses included history of myocardial infarction (heart attack), diabetes, hypertension (high blood pressure) and osteoarthritis. R3's service plan dated September 23, 2022, indicated ULPs would assist with support stockings (TEDS) twice daily. R3's Services Delivered, dated March 1, 2023, through April 5, 2023, indicated staff were assisting with TEDS twice daily. R3's record lacked prescriber orders for TEDS. On April 5, 2023, at 4:13 p.m., CNS-B stated R3 does not have an order for TEDS and was not aware an order was needed. The licensee's Medication and Treatment Orders policy dated July 21, 2022, indicated the RN is responsible for assuring that a current, authorized order for treatments administered by the staff are kept on file in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=D	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	02310		

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02310	Continued From page 139 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 with regards to safely storing oxygen for one of one oxygen storage area. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On April 3, 2023, at 1:32 p.m., the evaluator toured the facility with clinical nurse supervisor (CNS)-B, including a review of the small closet located in the hallway of wing two (2). The evaluator observed six tall oxygen cylinders positioned upright in the closet on the floor not stored secured in a holder. CNS-B stated all oxygen cylinders should be stored upright in a stand. The licensee's Oxygen policy dated July 21, 2022, indicated oxygen cylinders must remain upright at all times and stored in a well-ventilated area (not in closets). The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated	02310		

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02310	Continued From page 140 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: Seven (7) days	02310		
02320 SS=I	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for medication setup by unlicensed personnel (ULP) for one of one resident (R6). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems	02320		

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02320	Continued From page 141 are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate correction order on April 4, 2023, at approximately 2:30 p.m. The findings include: During the entrance conference on April 3, 2023, at 10:38 a.m., clinical nurse supervisor (CNS)-B stated the facility provided medication management services including medication set ups for residents and the medication set ups were completed by CNS-B and ULP-F. R6's diagnoses included diabetes type two, hypotension (low blood pressure), chronic pain and incontinence. R6's service plan was requested but not provided. R6's prescribers orders included acetaminophen-codeine (pain medication) 300-30 milligrams (mg) every morning and noon, Alogliptin (anti-diabetic) 12.5 mg tablet daily, aspirin 81 mg daily, calcium carbonate with vitamin D 600mg/400 units tablet daily, clopidogrel bisulfate (reduce heart disease) 75 mg daily, cyanocobalamin (B12 supplement) 500 micrograms (mcg) two tablets daily, ferrous sulfate 325 mg twice daily, fluoxetine (antidepressant) 20 mg capsule two capsules daily, levothyroxine (thyroid supplement) 125 mcg daily, loratadine 10 mg daily, pantoprazole (to treat gastric reflux) 20 mg daily, rosuvastatin (heart medication) 40 mg daily, triphrocaps (vitamin) 1 capsule daily and vitamin C 500 mg daily.	02320		

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02320	Continued From page 142 On April 4, 2023, at 10:50 a.m., CNS-B verified again ULP-F completed medication set ups for "the majority" of residents in bubble packs for multiple residents in the facility. CNS-B stated ULP-F was not a licensed staff member. CNS-B stated they do not document medication set ups anywhere in the resident record. CNS-B stated she was not aware that ULPs cannot complete medication set ups. The licensee's undated Medication Management-Medication Administration-Weekly Dosage Box Set Up, indicated a licensed nurse will transcribe the medication order onto the medication record, the licensed nurse will then set up the medications into the medication deck and will document the medication set up is complete on the medication record. According to the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making. MN Statute 144G.08, Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate As of survey exit on April 6, 2023, at 11:45 a.m., the immediacy of this order had not been removed.	02320		

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03000	Continued From page 143	03000		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should	03000		

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03000	Continued From page 144 determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R8) who had incidents of elopement. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On April 3, 2023, at 11:02 a.m., the evaluator asked clinical nurse supervisor (CNS)-B to provide the MAARC and incident reports for the last six months. The Incident Summary log dated October 1, 2022, through April 3, 2023, indicated R8 had two elopement incidents one on October 1, 2022, at 2:10 p.m., and one on March 29, 2023, at 6:00 p.m. No MAARC reports were provided.	03000		

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03000	Continued From page 145 R8's diagnoses included dementia, hypertension, and shortness of breath. R8's service plan dated October 5, 2022, indicated the resident received services to include behavior management, medication administration, safety checks, housekeeping, laundry and assistance with dressing and bathing. R8's assessments completed by CNS-B and dated November 25, 2022, and February, 28, 2023, indicated R8 was independent with mobility; was difficult to understand as she changes the topic to another quickly; R8 was at risk for elopement/wandering; R8 had a history of walking away from her home without informing her daughter; R8 also was identified as having disrobing behavior as R8 had been found several times in public areas without some clothing on; R8 was disorientated from reality; had severe cognitive impairment; and was a moderate fall risk. In addition, R8 had been identified as having patterns of wandering and noted R8 wanders inside the residence common areas but does not leave the building. R8 was identified as having wandering behavior with interventions that included: hourly checks and attempting to get a wander guard (a monitoring device in which the resident wears a bracelet and when the resident approaches a monitored door the sensor alerts the caregiver). R8's individual abuse prevention plan (which was incorporated into R8's assessment) dated February 28, 2023, noted R8 was not at risk to be abused by others or was not at risk to abuse other vulnerable adults. R8 was at risk to abuse herself and the specific measures to minimize this risk were to "monitor whereabouts. Supervise	03000		

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03000	Continued From page 146 interaction with other resident as possible, every two hour checks". R8's Elopement report dated October 1, 2022, at 2:10 p.m., noted R8 had activated the wander guard sensor twice and each time R8 had been redirected back in the building. A few minutes later the wander guard sensor went off again and staff were unable to find R8 in the facility or on the facility grounds. Staff went outside to look for R8 and found her at the gas station parking lot which was approximately three blocks away from the facility [which was next to a four-lane high traffic road]. The incident was reported to the facility manager and R8's daughter was notified. R8's record lacked documentation of a reassessment by the registered nurse (RN) following this incident. No MAARC report was provided for this incident of elopement. R8's Elopement report dated March 29, 2023, at 6:00 p.m., [recorded temperature for this evening was 19 degrees Fahrenheit, with winds at 9.8 miles per hour, making the outdoor temperature feel like 9 degrees F] noted R8 had been brought back to the facility by two people that said they found R8 about nine blocks away from the facility and they were wondering if she lived at the facility. The staff were not aware R8 had exited the building. Staff notified the RN that R8 had left the building, and someone had brought her back. R8's record lacked documentation of a reassessment by the RN following this incident. No MAARC report was provided for this incident of elopement. On April 3, 2023, at 3:29 p.m., CNS-B stated she considered R8 to be a "high" elopement risk.	03000		

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AUTUMN HILLS	2528 PARK AVENUE NW BEMIDJI, MN 56601

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03000	Continued From page 147 CNS-B stated an incident report should be completed and the RN should review all incident reports with any elopement. CNS-B stated, "this does not always get done". CNS-B stated the incident report was then put into the resident's file. CNS-B reviewed R8's Elopement report dated 10/1/22 and stated there was no follow up on the elopement incident or a reassessment completed by the RN following this incident. CNS-B reviewed R8's Elopement report dated March 29, 2023, and stated she had reviewed the incident on April 3, 2023, however, did not follow up on the elopement incident or complete a reassessment. CNS-B stated both of R8's elopement incidents were not reported to MAARC. CNS-B stated, "I didn't know what MAARC was". The licensee's undated Vulnerable Adults and Maltreatment-Communication, Prevention, and Reporting policy indicated all residents would be provided a copy of the Minnesota Bill of Rights for Home Care; staff would be provided training on maltreatment and the reporting requirements; the MAARC contact number; and that each client [resident] would have an individual abuse prevention plan developed. The policy did not include the definitions for a vulnerable adult, abuse, and neglect; the licensee's internal and external reporting procedure; and the timeline for reporting suspected cases of maltreatment, abuse, or neglect. On April 5, 2023, at 11:45 a.m., CNS-B reviewed the licensee's Vulnerable Adults and Maltreatment-Communication, Prevention, and Reporting policy and stated the policy was not completely developed and did not include the above noted areas. CNS-B stated she thought reports should be made to MAARC within 24	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30484	A. BUILDING: _____ B. WING _____	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HILLS	2528 PARK AVENUE NW 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
03000	Continued From page 148 hours. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

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

Type: Follow-Up
Date: *04/06/23*
Time: 11:29:14
Report: 3822231046

Food and Beverage Establishment Inspection Report

Location:
Autumn Hills of Bemidji, Inc.
2528 Park Avenue N.W.
Bemidji, MN56601
Beltrami County, 04

Establishment Info:
ID #: 0019006
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Shelley Cloose
Phone #: 2183333854
ID #: 22407

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

The following orders previously issued on 04/03/23 have NOT been corrected.

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COFFEE STATION IN DINING ROOM IS DETERIORATED. REPLACE WITH APPROVED CABINET ON 6" STAINLESS LEGS OR NSF STAINLESS TABLE.

Issued on: 04/03/23 *Comply By: 07/01/23*

No NEW orders were issued during this inspection.

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

ORDERS ADDRESSED. NO ADDITIONAL FOLLOW UP REQUIRED. LOREN SUBMITTED CFPM CERTIFICATE TODAY TO MDH.

Type: Follow-Up
Date: *04/06/23*
Time: 11:29:14
Report: 3822231046
Autumn Hills of Bemidji, Inc.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 3822231046 of 04/06/23.

Certified Food Protection Manager: Loren Tofstad

Certification Number: SEND (STATE) Expires: 05/05/26

Inspection report reviewed with person in charge and emailed.

Signed:_____

Loren Tofstad
Head Cook

Signed:_____

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

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

Type: Full
Date: *04/03/23*
Time: 12:20:07
Report: 3822231045

Food and Beverage Establishment Inspection Report

Location:

Autumn Hills of Bemidji, Inc.
2528 Park Avenue N.W.
Bemidji, MN56601
Beltrami County, 04

Establishment Info:

ID #: 0019006
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Shelley Cloose
Phone #: 2183333854
ID #: 22407

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

The following orders were issued during this inspection.

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.11A ***** Priority 1 *****

MN Rule 4626.0270A Do not allow food to contact surfaces of equipment and utensils that are not cleaned and sanitized.

OBSERVED MIXED FOOD UTENSIL STORAGE WITH VARIOUS ITEMS NOT RELATED TO FOOD SERVICE. ORGANIZE AND DEDICATE DRAWERS ACCORDINGLY.

Comply By: 04/06/23

2-100 Supervision

2-102.12AMN

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

LOREN TOFSTAD TOOK CLASS NOVEMBER OF 2022, BUT DID NOT TAKE EXAM. MUST HAVE CFPM BY FOLLOW UP INSPECTION.

Comply By: 04/06/23

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COFFEE STATION IN DINING ROOM IS DETERIORATED. REPLACE WITH APPROVED CABINET ON 6" STAINLESS LEGS OR NSF STAINLESS TABLE.

Comply By: 07/01/23

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

OBSERVED NO INTERNAL THERMOMETERS FOR COOLERS. PROVIDE NSF +/- 2 DEGREE THERMOMETERS.

Comply By: 04/06/23

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

OBSERVED GRIM ACCUMULATION ALONG FLOOR TO WALL COVING IN DISHWASHING ROOM. CLEAN AND MAINTAIN CLEAN.

Comply By: 04/06/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.14A

MN Rule 4626.1530A Maintain clean all intake and exhaust air ducts and change filters so they are not a source of contamination.

OBSERVED ACCUMULATED DUST IN CANOPY HOOD FOR DISHWASHER. CLEAN AND MAINTAIN CLEAN.

Comply By: 04/06/23

Surface and Equipment Sanitizers

Acid: = 700 PPM at Degrees Fahrenheit
Location: FOOD PREP/DINING ROOM TABLE SPRAY BOTTLE
Violation Issued: No

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

Food and Equipment Temperatures

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

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

Type: Full
Date: *04/03/23*
Time: 12:20:07
Report: 3822231045
Autumn Hills of Bemidji, Inc.

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	5

SERVING COLD HAM AND CHEESE SANDWICHES AND TOMATO SOUP TODAY.

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 3822231045 of 04/03/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____

Loren Tofstad
Head Cook

Signed:_____

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