Electronically delivered

December 3, 2021

Administrator
Aspen Grove Assisted Living
504 Iron Drive
Chisholm, MN 55719

RE: Project Number(s) SL30680015-1

Dear Administrator:

On November 23, 2021, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on September 10, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the September 10, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on September 10, 2021, found not corrected at the time of the November 23, 2021 follow-up evaluation and subject to penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144G.42, subd. 10 - $500.00
1640-Service Plan, Implementation, And Revisions T-144G.70, subd. 4
1960-Documentation Of Administration Of Treatments-144G.72, subd. 5
2040-Fire Protection And Physical Environment-144G.81, subd. 1 - $500.00

The details of the violations noted at the time of this follow-up evaluation completed on November 23, 2021 (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 $1,000**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on November 23, 2021, we identified the following violation(s):

0910-Contract Information-144G.50, subd. 2
0920-Contract Information-144G.50, subd. 2

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must

document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

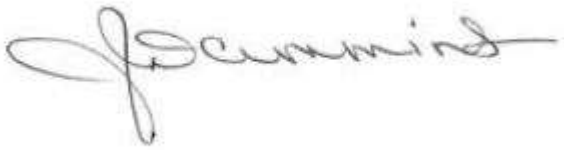
Alternatively, in accordance with Minn. Stat. § 144G.31, subd. 5 (d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, subd. 14 and subd. 16, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

We urge you to review these orders carefully. If you have questions, please contact Jeri Cummins at 218-302-6193.

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

Sincerely,



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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	**504 IRON DRIVE CHISHOLM, MN 55719**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders 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: Project # SL 3068015 On November 22, 2021, through November 23, 2021, surveyors of this Department's staff conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on September 10, 2021. At the time of the survey, there were 30 active residents receiving services under the Assisted Living Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
{0 680}	Continued From page 1 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency disaster plan with all the required content. This had the potential to affect all 30 residents receiving services under the assisted living with dementia care license. 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	{0 680}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
{0 680}	Continued From page 2	{0 680}		

resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

The licensee's plan provided to the surveyors included a Hazard Vulnerability Assessment dated August 1, 2021, which identified 12 events (such as fire, tornado, winter storm) and scored each event based on probability, risk and preparedness. The plan provided a generic outline of what should be included in an emergency preparedness plan with several checklist forms that could be used in emergencies, such as missing resident, water main break, gas line break, water/electrical outage, fire and natural disasters (tornado watch/warning, blizzard, and flooding). The licensee's plan included contact information for some external emergency and service contacts and natural disaster policies and procedures (not all customized to the facility). The emergency employee roster and emergency family/physician contact tabs were blank.

The licensee's plan did not include the following required content:
- a comprehensive program to include infectious diseases and pandemics;
- a description of the population served by the licensee;
- process for emergency preparedness (EP) cooperation with state and local EP officials/organizations;
- procedure for tracking staff and residents;
- subsistence needs for staff and residents during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
{0 680}	Continued From page 3	{0 680}		

emergency situation;
- development of policies/procedures to address:
  - evacuation plan;
  - fire;
  - shelter in place;
  - a tracking system used to document locations or residents and staff
  - the medical record documentation system to preserve resident information
  - emergency staff strategies
  - the facilities role in providing care and treatment at alternative sites
- a communication plan that included:
  - arrangement with other facilities
  - names and contact information for staff, resident physicians, other facilities
  - contact information for federal, state, tribal, local EP staff, ombudsman
  - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies
  - a method of sharing information and medical documentation for residents
  - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy
  -a method of sharing information from the emergency plan with residents and their families
- EP training and testing program
- EP testing/annual testing requirements

On November 23, 2021, at approximately 9:30 a.m., registered nurse (RN)-B confirmed the licensee had not fully developed and implemented the facility's emergency preparedness plan/program.

The licensee's 9.02 Disaster Planning and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
{0 680}	Continued From page 4 Emergency Preparedness policy dated August 30, 2021, noted the facility would have in place a general emergency preparedness plan in alignment with facility's requirement to also comply with CMS Appendix Z. No further information was provided.	{0 680}		
0 910 SS=C	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for four of four residents (R1, R3, R2, and R14) with record reviewed. This had the potential to affect all 30 residents receiving services under the assisted living with dementia care license. 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	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 910	Continued From page 5 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1, R2, R3, and R14's record lacked an assisted living contract to include: - the license number of the facility. R1 R1's Service Plan dated September 21, 2021, indicated services included assistance with activities of daily living, feeding, housekeeping, laundry and medication administration. R1's Individual Resident Placement Agreement (assisted living contract) dated September 21, 2021, lacked the license number of the facility. R2 R2's service plan, dated September 28, 2021, indicated the resident received services which included medication administration, weekly vitals signs and monthly weight monitoring, assistance with bathing and grooming, as well as assistance with dressing and continence care. R2's Individual Resident Placement Agreement (assisted living contract) dated September 26, 2021, lacked the license number of the facility. R3 R3's Service Plan dated September 20, 2021, indicated services included assistance with activities of daily living, wound care, housekeeping, laundry and medication administration. R3's Individual Resident Placement Agreement dated September 20, 2021, lacked the license number of the facility. On November 23, 2021, at approximately 7:10 a.m., unlicensed personnel (ULP)-C was	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 910	Continued From page 6 observed to administer R3 his scheduled morning medications. R14 R14's service plan, dated October 27, 2021, indicated the resident recieved services which included assistance with activities of daily living, wound care, housekeeping, laundry and medication administration. R14's Individual Resident Placement Agreement (assisted living contract) dated October 27, 2021, lacked the license number of the facility. On November 23, 2021, at approximately 9:05 a.m., registered nurse (RN)-B confirmed R1, R3, R2, R14 and all other residents assisted living contract did not include license number of the facility. The licensee's 1.05 Signing an Assisted Living Contract policy dated August 30, 2021, noted when a prospective resident is ready to sign a lease and move in fill in all the blanks of the contract and provide the prospective resident and/or responsible person a copy of the appropriate assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 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	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 920	Continued From page 7 assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for four of four residents (R1, R2, R3, and R14) with record reviewed. This had the potential to affect all 30 residents receiving services under the assisted living with dementia care license. 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).	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 920	Continued From page 8 The findings include: R1, R2, R3 and R14's assisted living contract lacked all the required content. R1 R1's Service Plan dated September 21, 2021, indicated services included assistance with activities of daily living, feeding, housekeeping, laundry and medication administration. R1's Individual Resident Placement Agreement (assisted living contract) dated September 21, 2021, lacked the following required content. - a delineation of the cost and nature of any other services to be provided for an individual fee; - a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; and - a disclosure of the facility's ability to provide specialized diets. R2 R2's service plan, dated September 28, 2021, indicated the resident received services which included medication administration, weekly vitals signs and monthly weight monitoring, assistance with bathing and grooming, as well as assistance with dressing and continence care. R3's Individual Resident Placement Agreement dated September 20, 2021, lacked the following required content. - a delineation of the cost and nature of any other services to be provided for an individual fee; - a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; and - a disclosure of the facility's ability to provide	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 920	Continued From page 9 specialized diets. R3 R3's Service Plan dated September 20, 2021, indicated services included assistance with activities of daily living, wound care, housekeeping, laundry and medication administration. On November 23, 2021, at approximately 7:10 a.m., unlicensed personnel (ULP)-C was observed to administer R3 his scheduled morning medications. R3's Individual Resident Placement Agreement dated September 20, 2021, lacked the following required content. - a delineation of the cost and nature of any other services to be provided for an individual fee; - a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; and - a disclosure of the facility's ability to provide specialized diets. R14 R14's service plan, dated October 27, 2021, indicated the resident recieved services which included assistance with activities of daily living, wound care, housekeeping, laundry and medication administration. R314s Individual Resident Placement Agreement dated October 27, 2021, lacked the following required content. - a delineation of the cost and nature of any other services to be provided for an individual fee; - a delineation and description of any additional fees the resident may be required to pay if the	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 920	Continued From page 10 resident's condition changes during the term of the contract; and - a disclosure of the facility's ability to provide specialized diets. On November 23, 2021, at approximately 9:10 a.m., registered nurse (RN)-B confirmed R1, R2, R3, R14 and all other residents' assisted living contract did not include the above noted required content. The licensee's 1.05 Signing an Assisted Living Contract policy dated August 30, 2021, noted when a prospective resident is ready to sign a lease and move in fill in all the blanks of the contract and provide the prospective resident and/or responsible person a copy of the appropriate assisted living contract. The policy did not include information specific to the content of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
{01640} SS=A	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The	{01640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
{01640}	Continued From page 11	{01640}		

facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care.
(c) The facility must implement and provide all services required by the current service plan.
(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.
(e) Staff providing services must be informed of the current written service plan.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the licensee to document agreement on the services to be provided for one of four residents (R13) with records reviewed.

This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at 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:

R13's service plan dated September 15, 2021, did not include a signature or other authentication by the licensee documenting agreement on the services provided.

On November 23, 2021, at approximately 8:10 a.m., registered nurse (RN)-A confirmed R13's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
{01640}	Continued From page 12 service plan did not include a signature by the licensee to authenticate the service plan agreement. The licensee's 6.08 Service Plan policy dated August 30, 2021, noted the service plan and any revisions would include a signature or other authentication by the licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided.	{01640}		
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not and any follow up procedures that were provided to meet the resident's needs for one of one resident (R2) with blood glucose (sugar) monitoring managed by the provider.	{01960}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
{01960}	Continued From page 13 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, but were not limited to, type II diabetes mellitus, hypertension, depression and anxiety. R2's service plan dated September 28, 2021, indicated the resident received services which included: medication administration, weekly vitals signs and monthly weight monitoring, assistance with bathing and grooming, assistance with dressing, and continence care. R2's medication administration record/MAR indicated R2 had blood sugars above 300 on November 6, 9, 10, 11, 12, 13, 20, 2021. The MAR included instructions for staff to call the registered nurse/RN if the resident's blood sugars were above 300 or below 60. The MAR did not have any place for staff to document if they contacted the RN or what follow up was taken. On November 23, 2021, at 9:20 a.m., RN-B confirmed that staff do call with an out of range blood sugar and she would provide instructions for staff on what to do. RN confirmed there was not any documentation on what she advised staff or any documentation from the staff to show they had placed a call to the RN.	{01960}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
{01960}	Continued From page 14 The licensee's 7.22 Medication & Treatment Record - Documentation & Refusal policy dated August 30, 2021, indicated other pertinent information would be entered, including things like a change in condition or new problems.	{01960}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a hazard vulnerability assessment for the facility. This had the potential to affect all 30 residents receiving services under the assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	{02040}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
{02040}	Continued From page 15 a large portion or all of the residents). The findings include: On November 22, 2021 at 10:30 a.m., records were provided to survey staff by office manager (OM)-J. On November 22, 2021, at approximately 11:15 a.m., owner-K confirmed during interview the facility failed to provide a copy of the hazard vulnerability assessment. Owner-K stated that he thought this assessment had been completed but a copy of the assessment was not included within the Emergency Action Plan binder dated August 2021. On November 22, 2021, at approximately 11:30 a.m., registered nurse (RN)-A confirmed during the exit interview that the facility failed to provide a copy of the hazard vulnerability assessment. (RN)-A stated that she thought this assessment had been completed and did not know where to locate a copy. On November 23, 2021, at 3:46 p.m., an electronic document titled "2021 - 504 Hazardous Vulnerability Assessment (program abuse prevention plan).docx" was emailed to survey staff by registered nurse (RN)-B. The plan development date listed was 11-22-2021. The prevention plan included physical plant and environmental risks assessments with specific measures listed to minimize risk.	{02040}		

Electronically Delivered

October 7, 2021

Administrator
Aspen Grove Assisted Living
504 Iron Drive
Chisholm, MN 55719

RE: Project Number(s) SL30680015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 10, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

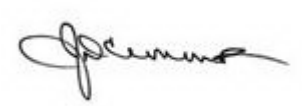
REQUESTING A HEARING

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, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSSITED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30680015 On, September 7, 2021 through September 10, 2021, surveyors of this Department's staff, visited the above provider and the following correction orders were issued. At the time of the survey, there was 29 clients that were receiving services under the Assisted Living Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 430 SS=F	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview, observation, and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services with the required content for three of three residents (R3, R1, R2) with records reviewed. This had the potential to affect all 29 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 client'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).	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 430	Continued From page 2 The findings include: Review of R3, R1, and R2's records lacked evidence a a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. R3 R3's diagnoses included, but were not limited to, hypertension (high blood pressure), dementia, atrial fibrillation (an irregular, often rapid heart rate), and hyperlipidemia (high cholesterol). R3's service plan dated December 16, 2020, indicated R3 received services which included medication administration, wound care, housekeeping, and bathing and grooming assistance. On September 8, 2021, at approximately 7:35 a.m., registered nurse (RN)-B was observed providing wound care to R3's lower right leg wound. At approximately 8:05 a.m., unlicensed personnel (ULP)-C was observed administering R3 his scheduled morning medications. R1 R1's diagnoses included, but were not limited to, dementia, depression, and anxiety. R1's service plan dated January 17, 2017,	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 430	Continued From page 3 indicated R1 received services which included medication administration and assistance with bathing, grooming, and dressing. On September 8, 2021, at approximately 8:15 a.m., ULP-H was observed providing feeding assistance to R1. R2 R2's diagnoses included, but were not limited to, Type II diabetes mellitus, hypertension, depression and anxiety. R2's service plan dated August 31, 2021, indicated R2 received services which included medication administration, weekly vitals signs and monthly weight monitoring, and assistance with bathing, grooming, dressing and continence care. On September 8, 2021, at approximately 8:30 a.m., ULP-G was observed checking R2's blood glucose. On September 9, 2021, at approximately 9:55 a.m., RN-A confirmed R3, R1, R2, and all other residents receiving services under the facility's license had not received a written checklist listing all services provided under the facility's license, and the services not provided under the facility's license. The licensee's 1.04 Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) policy dated August 30, 2021, noted the licensee would provide a Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to prospective residents prior to signing an Assisted Living contract. The facility would obtain written acknowledgement from the resident or resident's representative that they	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 430	Continued From page 4 provided the UDALSA or document the reason why an acknowledgement was not obtained. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 450 SS=D	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure utilization of person-centered planning and service delivery process for one of one resident (R9) with records reviewed. 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 an isolated scope (when one or a	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 450	Continued From page 5 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: R9's diagnoses included, but were not limited to, dementia, pulmonary emphysema (lung disease resulting in shortness of breath) and osteopenia (weak bones). R9's record lacked documentation in the service plan and care plan person-centered services. On September 8, 2021, at approximately 6:30 a.m., R9 was observed to be sitting in a wheelchair at the dining room table. On September 8, 2021, at 7:15 a.m., R9 was observed sitting with her face down against the dining room table. Unlicensed personnel (ULP)-H woke R9. ULP-G stated R9 liked to get up early, although she confirmed R9 frequently was found asleep at the dining room table in the mornings. ULP-H and ULP-G transferred R9 from her wheelchair to a recliner with total assist and a gait belt. On September 8, 2021, at 8:20 a.m., R9 was again observed sitting in a wheelchair at the dining room table. During the observation, R9 fell asleep and her face hit the table and her glasses fell off. ULP-H woke R9 and provided her breakfast. On September 9, 2021, at approximately 9:00 a.m., registered nurse (RN)-B confirmed R9 should have been allowed to sleep. RN-B stated residents should be served breakfast once at the table in the morning.	0 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 450	Continued From page 6 The licensee's 6.08 Service Plan policy dated August 30, 2021, noted services would be provided based on the needs and preferences of individual residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a means for four of four residents (R3, R8, R1, and R2) to	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 460	Continued From page 7 request assistance for health and safety needs as required. The licensee did not have a system in place for residents at the facility to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all 29 residents at the facility. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 31 residents. During the entrance conference on September 7, 2021, at approximately 1:55 p.m., registered nurse (RN)-A and RN-B confirmed the facility did not have a call system in place for residents to request assistance when needed. RN-A stated the staff were supposed to check on the residents every two hours. During the initial tour of the facility with RN-A on September 7, 2021, at approximately 2:30 p.m., it was observed the facility consisted of three (3) separate secure units (houses) which all opened to a common enclosed courtyard. Each secure unit had a capacity to house a total of ten to eleven residents. The current census at the facility was 29 residents.	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 460	Continued From page 8 R3 R3's diagnoses included, but were not limited to, hypertension (high blood pressure), dementia, atrial fibrillation (an irregular, often rapid heart rate), and hyperlipidemia (high cholesterol). R3 resided in secure unit #2. On September 8, 2021, at approximately 6:00 a.m., R3 was observed dressed and walking around in the open living room/dining room area with a cup of coffee in his hands. R3 was unable to articulate how he would call for assistance, if needed. R8 R8's diagnoses included, but were not limited to, diabetes, congested heart failure (CHF- a condition in which the heart's function as a pump is inadequate to meet the body's needs), hypertension, and Parkinson's disease (a chronic progressive neurological disease which exhibits symptoms such as tremors, rigidity, impaired balance, slowness of movement and a shuffling gait). R8 resided in secure unit #2. On September 8, 2021, at approximately 7:15 a.m., R8 was observed walking with a walker in the open dining room area. R8 had a cast on her right lower arm/wrist area. On September 8, 2021, at approximately 8:10 a.m., when asked how she would request staff assistance when she needed it, R8 stated she hollers out for help. R1 R1's diagnoses included, but were not limited to, dementia, anxiety and depression. R1 resided in the secure unit #3. On September 8, 2021, at approximately 8:15 a.m., R1 was observed being fed by unlicensed personnel	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 460	Continued From page 9 (ULP)-H in the dining room. R1 was unable to indicate how she would request assistance, if needed. R2 R2's diagnoses included, but were not limited to, Type II diabetes mellitus, hypertension, depression and anxiety. R2 resided in the secure unit #3. On September 8, 2021, at approximately 8:30 a.m., R2 was observed having her blood glucose checked by ULP-G in her bedroom. When asked she would request staff assistance when she needed it, R2 stated she finds the staff. A policy regarding the facility's call system was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 470	Continued From page 10 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 29 residents and staff. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility with dementia care license. The facility was licensed for a bed capacity of 31 residents and had a current census of 29 residents.	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 470	Continued From page 11 During the entrance conference on September 7, 2021, at approximately 1:40 p.m., Registered Nurse (RN)-B was identified as the clinical nurse supervisor. On September 9, 2021, at 1:30 p.m., Office Manager (OM)-J stated one of her responsibilities was to make the staffing schedule, which was then approved by RN-A. OM-J further indicated the staff schedule was created based on the needs of the residents; however, OM-J was unable to explain what criteria was used to determine how many staff members were schedule per shift for each of the three resident care units. The licensee's 4.06 Staffing & Scheduling policy dated August 30, 2021, indicated the clinical nurse supervisor would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 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	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 480	Continued From page 12 fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; 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 comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all 29 residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports dated September 7, 2021.	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 480	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. 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 one of three unlicensed personnel (ULP)-G) providing personal cares. In addition, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to COVID-19. This had the potential to affect all 29 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 510	Continued From page 14	0 510		

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:

HAND HYGIENE
On September 8, 2021, at approximately 7:45 a.m., ULP-G was observed assisting ULP-H providing transferring and toileting assistance to R13. ULP-G and ULP-H both had gloves on during the observation while R13 was transferred from bed to wheelchair and then wheelchair to toilet. ULP-G removed R13's soiled brief and put a clean brief on R13. As ULP-G and ULP-H stood R13 up with a transfer belt, ULP-G provided perineal care to R13 using the same gloved hands. After R13 was transferred from the toilet to wheelchair, ULP-G removed her gloves and continued assisting R13 with dressing. At approximately 7:55 a.m., ULP-G was observed washing her hands at the sink with soap and water.

On September 9, 2021, at approximately 10:05 a.m., Registered Nurse (RN)-A stated her expectations would be for staff to complete hand hygiene whenever their gloves were changed.

The licensee's 8.07 Gloves policy dated August 30, 2021, noted staff should wash their hands prior to donning gloves and after doffing gloves.

The licensee's 8.09 Hand Washing policy dated August 30, 2021, noted staff should complete proper hand washing techniques including, but not limited to, after changing diapers or cleaning up after someone who as used the toilet, as well as between tasks and procedures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 510	Continued From page 15 COVID-19 On September 9, 2021, at approximately 9:20 a.m., RN-A stated it was the licensee's expectations that staff follow the current Minnesota Department of Health (MDH) and Center for Disease Control and Prevention (CDC) guidelines with regards to COVID-19. COVID-19 EMPLOYEE SCREENING The licensee lacked evidence employees were screened prior to entering the facility and that the screening included COVID-19 symptom screening. The MDH document titled, COVID-19 Toolkit, Information for Long Term Care Facilities, dated March 8, 2021, indicated on page 7 all staff should be screened for fever and symptoms of illness before starting each shift. This includes an assessment for fever (measured temperature higher than 100.0 degrees Fahrenheit) or subjective fever (chills, feeling feverish) and asked about new symptoms of illness that cannot be attributed to another diagnosis (sore throat, diarrhea, abdominal pain, fatigue, chills, shortness of breath, or new loss of taste or smell). On September 8, 2021, at approximately 5:50 a.m., ULP-F entered the facility and walked through the facility into the kitchen area. ULP-F was not screened or monitored for COVID-19 symptoms. On September 8, 2021, at approximately 6:00 a.m., ULP-C entered the facility and walked into the kitchen area past two residents who were in the open dining room area. ULP-D was observed to take and record ULP-C's temperature: however, ULP-D did not screen ULP-C for	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 510	Continued From page 16 symptoms of COVID-19. The licensee's Coronavirus Staff Screening Tool dated September 5, 2021, through September 9, 2021, provided the following directions for "daily employee temperature and symptoms check - record temp [temperature] daily and check the date box if you have zero of the symptoms: fever, cough, shortness of breath, fatigue, muscle or body aches, loss of taste or smell, sore throat, chills, runny nose, nausea and vomiting, diarrhea, or known contact." Next to each staff member's name and the date they worked, a temperature reading was recorded; however, there was no checkmark by the date to indicate the staff member was free from COVID-19 symptoms. On September 9, 2021, at approximately 9:30 a.m., RN-A stated the employees were supposed to be screened at the entrance of the building prior to them entering the facility by the designated screener for that shift. RN-A stated employees should have their temperature taken, asked the symptom screening questions, and document the results on the staff screening log. COVID-19 RESIDENT SCREENING AND MONITORING The licensee lacked evidence that three of three residents (R3, R1, R2) were monitored for oxygen saturation levels and screened for COVID-19 symptoms at least daily. The MDH guidance document titled, COVID-19 Toolkit, Information for Long Term Care Facilities, dated March 8, 2021, indicated all residents should be actively screened for fever and symptoms consistent with COVID-19 at least daily. If a pulse oximeter was available, daily pulse oximetry screening was recommended with	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 510	Continued From page 17	0 510		

charting of clinical measurements and symptoms for each resident.

R3, R1, and R2's records did not contain evidence of daily COVID-19 screening and monitoring, including no pulse oximetry readings or symptom screening.

The licensee's Daily Resident COVID-19 Temperature Log dated August 29, 2021, through September 9, 2021, included documentation of daily temperature results for R3, R1, R2 and all other residents at the facility; however, there was no documenation of pulse oximetry readings or COVID-19 symptom screening of the residents.

On September 9, 2021, at approximately 9:35 a.m., RN-A and RN-B confirmed the licensee had a pulse oximeter. RN-A verified R3, R1, R2 and all other residents at the facility were not monitored for oxygen saturation levels or screened daily for COVID-19 symptoms as required.

VISITOR COVID-19 SCREENING
The licensee failed to ensure visitors were appropriately screened prior to entry into the facility.

The MDH document titled, COVID-19 Toolkit, Information for Long Term Care Facilities, dated March 8, 2021, indicated on page 7 that health screening should be conducted for other essential health care personnel including, but not limited to, state surveyors.

On September 7, 2021, at approximately 1:40 p.m., three MDH surveyors were allowed entrance into the facility by RN-B. RN-B did not take the surveyors' temperatures or ask the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 510	Continued From page 18	0 510		

surveyors COVID-19 symptom screening questions. In addition, it was known that an MDH Sanitarian entered the building to conduct his investigation around 9:30 a.m.; on this date a symptom screening was not completed.

On September 8, 2021, at approximately 5:45 a.m., an MDH surveyor entered the facility and was greeted by ULP-E. ULP-E did not take the surveyor's temperature or ask COVID-19 symptom screening questions.

The licensee's Visitor Log dated August 9, 2021, through September 7, 2021, did not include documentation that the MDH Sanitarian had been screened and monitored for COVID-19 symptoms on the date he had entered (September 7, 2021).

On September 7, 2021, at approximately 3:35 p.m., RN-A confirmed all visitors, including MDH surveyors, should have their temperature taken and complete COVID-19 symptom screening upon entry into the facility.

EYE PROTECTION
The MDH document titled, COVID-19 Toolkit, Information for Long Term Care Facilities, dated March 8, 2021, indicated on page 8 that all staff should wear a well-fitting mask and eye protection (e.g. face shield, goggles) when in resident care areas.

The MDH document titled, COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings, dated April 23, 2021, noted healthcare workers with face-to-face contact with residents should wear a medical grade well-fitting mask and eye protection.

On September 7, 2021, at approximately 1:40

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 510	Continued From page 19 p.m., upon entrance to the facility, RN-A and RN-B were observed in resident care areas not wearing eye protection. On September 7, 2021, at approximately 2:20 p.m., RN-A confirmed staff were not wearing eye protection. RN-A was unaware of the current PPE guidelines specific to the use of eye protection. On September 8, 2021, at approximately 5:45 a.m., ULP-E was observed in a resident care area not wearing eye protection. At approximately 6:00 a.m., ULP-C was observed in a resident care area not wearing eye protection. At approximately 6:30 a.m., ULP-H was observed in a resident care area not wearing eye protection. AEROSOL-GENERATING PROCEDURES The MDH document titled, Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19, dated June 18, 2020, indicated nebulizer treatments should be administered in the resident's room with the door closed. R6's diagnoses included, but were not limited to, nicotine dependency, dementia, and chronic obstructive pulmonary disease (COPD- chronic obstruction of lung airflow that interferes with normal breathing). R6's Service Plan dated January 2, 2017, and Medication/Treatment/Therapy Management Plan dated March 4, 2019, indicated R6 received medication administration services. R6's prescriber orders dated January 13, 2021, included, but were not limited to, an order for	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 510	Continued From page 20 Budesonide 0.5 milligram (mg) nebulizer treatment to be administered twice daily (an corticosteroid inhalation treatment to help decrease inflammation in the lungs). R6 also had a prescriber order dated August 13, 2021, for DuoNeb 0.5-3 (2.5) mg/ 3 milliliters to be administered four times a day (a bronchodilator inhalation treatment). On September 8, 2021, at approximately 9:35 a.m., a nebulizer machine was observed on a corner shelf in the open dining room area, which was a high traffic area for both staff and residents. ULP-C confirmed the nebulizer machine was for R6. ULP-C stated when COVID-19 was bad, the staff administered R6's nebulizer treatments in the closed family room. ULP-C confirmed more recently R6 received his nebulizer treatments (which were ordered several times a day) in the open dining room area. On September 9, 2021, at approximately 9:25 a.m., RN-B confirmed R6 should receive his nebulizer treatments in his room with the door closed and not in the open dining room area. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances.	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 550	Continued From page 21 The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post required information related to the licensee's grievance procedure, contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities, and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all 29 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities,	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 550	Continued From page 22 or any information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). During a facility tour on September 7, 2021, at approximately 2:00 p.m., it was observed the three unit common areas lack the required posting of the grievance procedure and information related to reporting suspected maltreatment to MAARC. On September 9, 2021, at approximately 2:45 p.m., registered nurse (RN)-B confirmed the required content noted above was not posted as required. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated August 30, 2021, noted the licensee would post information for reporting suspected crime and maltreatment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 630 SS=E	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 630	Continued From page 23 and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure development of an individual abuse prevention plan with the required content for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included, but were not limited to, dementia, depression and anxiety. R1's service plan dated January 27, 2017, indicated R1 received services which included medication administration and assistance with bathing, grooming and dressing. On September 8, 2021, at approximately 8:15 a.m., unlicensed personnel (ULP)-H was observed providing feeding assistance to R1. R1's Vulnerability Assessment/Abuse Prevention Plan dated January 27, 2017, identified areas of	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 630	Continued From page 24 vulnerability with interventions in the following areas: orientation to person, place, and time; ability to understand and/or follow instructions; risk for falls; aggression towards others; wandering; unable to call for help; and unable to report abuse, neglect or other concerns. R1's assessment did not include a review of R1's risk of abusing other vulnerable adults and indicated R1 did not appear to have any areas of vulnerability requiring intervention despite notation of the above mentioned areas of vulnerability. In addition, the assessment did not include a review of R1's susceptibility to be abused by another individual, including other vulnerable adults. On September 9, 2021, at 10:00 a.m., registered nurse (RN)-A confirmed R1's assessment did not address the above noted areas of risk. R2 R2's diagnoses included, but were not limited to, Type II diabetes mellitus, hypertension, depression and anxiety. R2's service plan dated August 31, 2021, indicated R2 received services which included medication administration, weekly vitals signs and monthly weight monitoring, and assistance with bathing, grooming, dressing and continence care. On September 8, 2021, at approximately 8:30 a.m., ULP-G was observed checking R2's blood glucose. R2's Vulnerability Assessment/Abuse Prevention Plan dated August 31, 2021, identified areas of vulnerability with interventions in the following areas: orientation to person, place, and time; visual difficulties; hearing difficulties; ability to	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 630	Continued From page 25 understand and/or follow instructions; aggression towards others; and risk for falls. R2's assessment did not include a review of R2's susceptibility to be abused by another individual, including other vulnerable adults. On September 9, 2021, at approximately 9:35 a.m. RN-A confirmed R2 was able to report abuse although the assessment did not indicate R2's ability to do so. R3 R3's diagnoses included, but were not limited to, hypertension (high blood pressure), dementia, atrial fibrillation (an irregular, often rapid heart rate), and hyperlipidemia (high cholesterol). R3's service plan dated December 16, 2020, indicated R3 received services which included medication administration, wound care, housekeeping, and assistance with bathing and grooming. On September 8, 2021, at approximately 7:35 a.m., RN-B was observed providing wound care to R3's lower right leg wound. At approximately 8:05 a.m., ULP-C was observed administering R3's scheduled morning medications. R3's Vulnerability Assessment/Abuse Prevention Plan dated December 16, 2020, identified areas of vulnerability with interventions in the following areas: orientation to person, place, and time; ability to understand and/or follow instructions; risk for falls; verbal aggression towards others; and unable to call for help. R3's assessment lacked a review of R3's susceptibility to be abused by another individual, including other vulnerable adults, and R3's risk of abusing other vulnerable adults.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 630	Continued From page 26 On September 9, 2021, at approximately 9:40 a.m., RN-A confirmed R3's Vulnerability Assessment/Abuse Prevention Plan did not include the assessment or review of the R3's susceptibility to be abused by another individual, including other vulnerable adults or R3's risk of abusing other adults. The licensee's 6.05 Individual Abuse Prevention Plan policy dated August 30, 2021, noted the licensee would develop and implement an individual abuse prevention plan for each vulnerable adult. The plan would contain an individualized review or assessment of the person's susceptibility to abuse by another individual including other vulnerable adults, the person's risk of abusing other vulnerable adults, and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 640	Continued From page 27 to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content in common areas to include: posting the 911 emergency number in common areas and near telephones provided by the assisted living facility and posting information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had the potential to impact all 29 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living. In addition, there was no evidence of the contact information or reporting number for the Minnesota Adult Abuse Reporting Center (MAARC). During tour of the facility on September 7, 2021, at approximately 2:00 p.m., it was observed the three unit common areas did not have the	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 640	Continued From page 28 required postings for the 911 emergency number and the reporting number for MAARC. On September 8, 2021, at approximately 6:45 a.m., an observation of the telephone in unit #3's den did not have the 911 emergency number or the reporting number for MAARC posted by the telephone. On September 9, 2021, at approximately 2:45 p.m., Registered Nurse (RN)-B confirmed the required content noted above was not posted by the licensee as required. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated August 30, 2021, noted the licensee would post the 911 emergency number in common areas and near telephones provided by the assisted living and would post information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
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	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 680	Continued From page 29 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all 29 residents receiving services under the assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 680	Continued From page 30 The findings include: During the entrance conference on September 7, 2021, at approximately 2:20 p.m., an MDH surveyor requested to view the licensee's emergency preparedness plan, which was provided to and later reviewed by the surveyor. On September 7, 2021, at approximately 2:40 p.m., MDH surveyors toured the facility with registered nurse (RN)-A and RN-B. The facility's physical layout included three (3) separate, unattached secure units (houses) which all opened to a common enclosed courtyard. There was no observed signage posted or information regarding the licensee's emergency plan in any of the three houses' main entrances or elsewhere in the facility. The licensee's plan provided to the surveyors included a Hazard Vulnerability Assessment dated August 1, 2021, which identified 12 events (such as fire, tornado, winter storm) and scored each event based on probability, risk and preparedness. The plan provided a generic outline of what should be included in an emergency preparedness plan with several checklist forms that could be used in emergencies, such as missing resident, water main break, gas line break, water/electrical outage, fire and natural disasters (tornado watch/warning, blizzard, and flooding). The licensee's plan included contact information for some external emergency and service contacts and natural disaster policies and procedures (not all customized to the facility). The emergency employee roster and emergency family/physician contact tabs were blank. The licensee's plan did not include the following	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 680	Continued From page 31 required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility) - shelter in place; - a tracking system used to document locations or residents and staff - the medical record documentation system to preserve resident information - emergency staff strategies - the facilities role in providing care and treatment at alternative sites - a communication plan that included: - arrangement with other facilities - names and contact information for staff, resident physicians, other facilities - contact information for federal, state, tribal, local EP staff, ombudsman - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies - a method of sharing information and medical documentation for residents - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy -a method of sharing information from the	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 680	Continued From page 32 emergency plan with residents and their families - EP training and testing program - EP training program for staff (including documentation of training provided) - EP testing/annual testing requirements On September 9, 2021, at approximately 2:15 p.m., RN-A confirmed staff were not familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] State Operations Manual which includes the emergency preparedness guidelines). RN-A verified the licensee had not fully developed and implemented the facility's emergency preparedness plan/program. The licensee's 9.02 Disaster Planning and Emergency Preparedness policy dated August 30, 2021, noted the facility would have in place a general emergency preparedness plan in alignment with facility's requirement to also comply with CMS Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes;	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 780	Continued From page 33 (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, a smoke alarm in a resident room had been compromised. In addition, the facility failed to provide two smoke alarms in the hallways. 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 client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 8, 2021, between 9:45 a.m. and 1:15 p.m., survey staff toured the facility with Registered Nurse (RN)-A and Office Manager (OM)-J.	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 780	Continued From page 34 COMPROMISED SMOKE ALARMS On September 8, 2021, at 11:00 a.m., it was observed tape was placed over the smoke alarm in the sleeping room of R6. On September 8, 2021, at approximately 11:00 a.m., OM-J stated she did not know tape had been placed on the smoke alarm. MISSING SMOKE ALARMS On September 8, 2021, at 10:15 a.m., two smoke alarms were observed unplugged and removed from the ceiling in the main hallways. On September 8, 2021, at 10:15 a.m., RN-A confirmed she did not know the smoke alarms were missing. The licensee's 9.03 Physical Plant Requirements policy dated August 30, 2021, noted the licensee would comply with the site, physical environment, and fire safety requirements. The licensee would provide and maintain a smoke alarm in each room used for sleeping purposes. A smoke alarm outside each sleeping room. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 790	Continued From page 35 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, fire extinguishers were not being maintained. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On September 8, 2021, between 9:45 a.m. and 1:15 p.m., survey staff toured the facility with Registered Nurse (RN)-A and Office Manager (OM)-J. On September 8, 2021, between 9:45 a.m., and 1:15 p.m., fire extinguishers located in kitchens were observed with no labels or tags attached indicating when maintenance was performed. On September 8, 2021, during the exit conference at approximately 1:30 p.m., Owner-K	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 790	Continued From page 36 confirmed he did not know annual maintenance was required for portable fire extinguishers. The licensee's 9.03 Physical Plant Requirements policy dated August 30, 2021, noted the licensee would comply with the site, physical environment, and fire safety requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility was not being maintained in a continuous state of good repair. 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 client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 800	Continued From page 37 The findings include: On September 8, 2021, between 9:45 a.m. and 1:15 p.m., survey staff began the tour with Registered Nurse (RN)-A and finished the tour with office manager (OM)-J. The following observations were made during the facility tour on September 8, 2021: -Sidewalks within the outdoor activity space were cracked and chipped in multiple locations, creating a tripping and fall hazard; -The exterior exit door of house #1, located within the storage room was sticking badly, making it difficult to open; -On the exterior wall of house #1 above the patio area, there were capped electrical wires near the roof; -The uncovered outdoor electrical outlet adjacent to patio on house #2 was not secured to the outlet box; -In community bathroom of house #2, the folding shower bench had two slats that were disconnected from the front side of the frame; -The cover for the exhaust vent was missing in the bathroom of R8 in house #2; and -Two holes in the wall were observed in the bathroom of R6 in house #2. On September 8, 2021, during the facility tour, a resident commented the outlet outside of house #2 still worked. At 11:40 a.m., three unsupervised residents were observed on the patio adjacent to the outlet. The licensee's 9.03 Physical Plant Requirements policy dated August 30, 2021, noted the licensee would comply with the site, physical environment, and fire safety requirements. In addition, all	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 800	Continued From page 38 weather roads and walks would be provided and maintained. The physical environment would be maintained in a good repair and operation in accordance with a maintenance and repair program. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 39 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 interview and record review, the facility failed to provide the required documentation on fire safety and evacuation plans, as well as required evacuation drills. In addition, the facility failed to provide documentation on staff training and training plan frequency related to evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 8, 2021, between 9:45 a.m. and 1:15 p.m., survey staff toured the facility with Registered Nurse (RN)-A and office manager (OM)-J, which included document review. Survey staff requested the facility fire safety and evacuation plans for review. EVACUATION PLAN The facility documentation did not include the	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 40 following: a. Details of evacuation routes for fire safety and emergencies on the facility floor plans posted within each of the three houses; room names and/or numbers were illegible on posted evacuation floor plans and identifiers for many of the resident rooms were not provided in hallways or on doors. b. A plan that included accurate instructions on fire protection procedures necessary for residents. In the Fire Protection and Physical Environment plans provided, the following items were noted: -Magnetic door holders were referenced, which the facility did not have; -The plan noted residents should stay behind fire doors, but locations of these fire doors were not identified; -The plans noted that all should be evacuated to the safest exit or behind nearest set of smoke compartment doors, although locations of these smoke compartment doors were not identified; and c. Procedures necessary for residents including their movements, and relocation during a fire or similar emergency, and written instructions for addressing unique situations for residents who are needing assistance during evacuation. EVACUATION DRILL The facility documentation did not include: -Documentation of employee evacuation drills. On September 8, 2021, at 1:00 p.m., OM-J stated the licensee had not documented these drills. No plans for frequency of these drills were provided STAFF TRAINING On September 8, 2021, between 9:45 a.m. and 1:15 p.m., survey staff toured the facility, which	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 41 included document review. Survey staff requested the fire safety and evacuation training plans for review. The facility documentation did not include: -required records on training of employees on fire safety and evacuation. On September 8, 2021, at 1:00 p.m., OM-J stated training was provided to new employees. OM-J was unable to provide documentation of the completed staff training or the staff training plan. The licensee's 9.07 Fire Safety, Evacuation Plan, Fire Drills policy dated August 30, 2021, noted fire/evacuation drills for staff were required to be conducted six times per year. Drills must be conducted ever other month. Each shift shall participate in at least two drills per year. Drills would be documented. In addition, all employee's would be trained on the fire safety and evacuation plans upon hire and at least twice per year thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing;	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 900	Continued From page 42 (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute a written contract with the required content to provided assisted living services for three of three residents (R1, R2, R3) with records reviewed. This has the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a client's health or	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 900	Continued From page 43 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: R1, R2, and R3's records lacked a written contract which included all of the terms concerning the provisions of the following as required: (1) housing (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable In addition, R1, R2, and R3 records lacked evidence that the contract had been fully executed as the facility must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; - 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; and - the facility must offer the resident the opportunity to identify a designated representative. R1 R1's diagnoses included, but were not limited to, dementia, depression and anxiety. R1's service plan, dated January 27, 2017,	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 900	Continued From page 44 indicated R1 received services which included medication administration and assistance with bathing, grooming and dressing. On September 8, 2021, at approximately 8:15 a.m., unlicensed personnel (ULP)-H was observed providing feeding assistance to R1. R2 R2's diagnoses included, but were not limited to, Type II diabetes mellitus, hypertension, depression and anxiety. R2's service plan dated August 31, 2021, indicated R2 received services which included medication administration, weekly vitals signs and monthly weight monitoring, assistance with bathing, grooming, dressing and continence care. On September 8, 2021, at approximately 8:30 a.m., ULP-G was observed checking R2's blood glucose. R3 R3's diagnoses included, but were not limited to, hypertension, dementia, atrial fibrillation (an irregular, often rapid heart rate), and hyperlipidemia (high cholesterol). R3's service plan dated December 16, 2020, indicated R3 received services which included medication administration, wound care, housekeeping, and assistance with bathing and grooming. On September 8, 2021, at approximately 7:35 a.m., Registered Nurse (RN)-B was observed providing wound care to R3's lower right leg wound. At approximately 8:05 a.m., ULP-C was observed administering R3 his scheduled	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
0 900	Continued From page 45 morning medications. On September 8, 2021, at approximately 12:10 p.m., RN-A confirmed a contract had not been developed or executed for the licensee's 29 current residents as required. The licensee's 1.05 Signing an Assisted Living Contract policy dated August 30, 2021, noted when a prospective resident decides to move into the facility a signed Assisted Living contract must be signed and received by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 46 attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative for three of three residents (R1, R2 and R3) with records reviewed. This has the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included, but were not limited to, dementia, depression and anxiety. R1's service plan dated January 27, 2017, indicated R1 received services which included medication administration and assistance with bathing, grooming and dressing.	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 47 R1's Resident Information form dated January 27, 2017, indicated R1 had a supportive husband and family. R1's record did not contain a notice with the required statutory language for R1 to identify a designated representative or documentation that R1 declined to name a designated representative. R2 R2's diagnoses included, but were not limited to, Type II diabetes mellitus, hypertension, depression and anxiety. R2's service plan dated August 31, 2021, indicated R2 received services which included medication administration, weekly vitals signs and monthly weight monitoring, and assistance with bathing, grooming, dressing and continence care. R2's Resident Information form dated August 31, 2021, indicated R2 had a supportive niece and nephew. R2's record did not contain a notice with the required statutory language for R2 to identify a designated representative or documentation that R2 declined to name a designated representative. R3 R3's diagnoses included, but were not limited to, hypertension (high blood pressure), dementia, atrial fibrillation (an irregular, often rapid heart rate), and hyperlipidemia (high cholesterol). R3's service plan dated December 16, 2020, indicated R3 received services which included medication administration, wound care, housekeeping, and assistance with bathing and	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 48 grooming. R3's Resident Information form dated December 16, 2020, indicated R3 did not have any family support, but did have friends and neighbors listed as being a support to him. R3's record did not contain evidence of a notice with the required statutory language for R3 to identify a designated representative or documentation that R3 declined to name a designated representative. On September 9, 2021, at approximately 9:55 a.m., registered nurse (RN)-A confirmed R1, R2, R3, and all other residents at the facility had not been provided the opportunity to identify a designated representative. The licensee's 1.08 Designated Representative policy dated August 30, 2021, noted before or at the time of execution of an assisted living contract the licensee would offer residents the opportunity to identify a designated representative in writing. A signed Designated Representative form would be filled out documenting the resident's choice in designated representative, and the form would be kept in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
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	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01460	Continued From page 49	01460		

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 (RN-B, ULP-C, and ULP-G) with records reviewed. This has the potential to affect all residents. This has the potential to affect all residents.

This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

Registered nurse (RN)-B, unlicensed personnel (ULP)-C and ULP-G were hired on August 1, 2021, to provide direct care services to the licensee's residents.

On September 8, 2021, at approximately 7:35 a.m., RN-B was observed providing direct care services for R3, which included wound care to R3's right lower leg wound.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01460	Continued From page 50 On September 8, 2021, at approximately 8:05 a.m., ULP-C was observed providing direct care services for R3, which included administering R3's scheduled morning medications. On September 8, 2021, at approximately 8:30 a.m., ULP-G was observed providing direct care services for R2 which included checking R2's scheduled blood glucose. RN-B, ULP-C and ULP-G's employee records did not contain documentation of completed orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. On September 9, 2021, at approximately 2:10 p.m., RN-B confirmed herself, ULP-C, ULP-G and all other employees at the facility had not completed orientation to assisted living facility licensing requirements and regulations as required. The licensee's 5.01 Orientation of Staff and Supervisors and Content policy dated August 30, 2021, noted all staff providing and supervising direct services would complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01540	Continued From page 51 (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received the required amount of dementia care training in the required time frame for one of three employees (RN-B) records reviewed. 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 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 had a current assisted living facility with dementia care license.	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01540	Continued From page 52 Registered Nurse (RN)-B was hired on August 1, 2021, to provide direct care services to the licensee's residents. On September 8, 2021, at approximately 7:35 a.m., RN-B was observed providing direct care services for R3, which included wound care to R3's right lower leg wound. RN-B's employee record did not contain documenation RN-B completed the required eight (8) hours of training on the specific dementia care topics within 80 working hours of RN-B's hire date. On September 9, 2021, at approximately 2:15 p.m., RN-B confirmed she had not completed the above noted dementia training as required. The licensee's 5.03 Dementia Training policy dated August 30, 2021, noted direct care employees of assisted living with dementia care licensed facilities would complete eight hours of initial training within 80 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01540		
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.	01560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01560	Continued From page 53 (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. 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). Findings include: During the entrance conference on September 7, 2021, at approximately 2:00 p.m., registered nurse (RN)-A stated the facility was licensed as an assisted living facility with dementia care. RN-A stated the facility provided staff dementia training, but did not have a written dementia	01560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01560	Continued From page 54 training disclosure form to provide to anyone who requested. The licensee's 3.08 ALDC Notice of Dementia Training policy, dated August 30, 2021, indicated the facility would make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01610 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01610	Continued From page 55 planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a Registered Nurse (RN) conducted an initial assessment for one of one resident (R2) as required with records reviewed. 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 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 was admitted for services on August 31, 2021. R2's diagnoses included, but were not limited to, diabetes Type II, hypertension (high blood pressure), depression and anxiety. R2's service plan dated August 31, 2021, indicated R2 received services which included medication administration, bathing, dressing, grooming, and incontinence care services, and weekly vital signs and monthly weight monitoring, as well as daily activities. R2's record included a RN Evaluation/Comprehensive Assessment dated August 31, 2021. This assessment indicated R2 required assistance with dressing, hygiene, bathing, toileting and incontinence care, transferring, housekeeping/laundry, and	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01610	Continued From page 56 medication administration. This assessment did not include all the elements on the uniform assessment tool as required. On September 8, 2021, at approximately 8:30 a.m., unlicensed personnel (ULP)-G was observed checking R2's blood glucose level. On September 9, 2021, at 9:45 a.m., RN-A confirmed R2's assessment did not include all required content of the uniform assessment tool. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 30, 2021, indicated a registered nurse would assess the physical and cognitive needs of prospective clients and the assessment must include all the elements of the uniform assessment tool as required. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=E	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 57 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool on day 90 for four of four residents (R3, R4, R8, and R1) as required with records reviewed. 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: R1 - 90 DAY ASSESSMENT R1's diagnoses included, but were not limited to, dementia, depression and anxiety.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 58 R1's service plan dated January 27, 2017, indicated R1 received services which included medication administration and assistance with bathing, grooming and dressing. R1's record included an RN Evaluation/Comprehensive Assessment dated January 15, 2021. R1's record did not contain an every 90 day assessment by an RN as required; no further assessments were included R1's record. R1's 90 day assessments were due: -April 15, 2021; and July 14, 2021. On September 8, 2021, at approximately 8:00 a.m., unlicensed personnel (ULP)-H was observed providing feeding assistance to R1. At 8:20 a.m., R1 was observed with deceibrate posturing (abnormal rigidity) which caused R1 to begin to slip out of her wheelchair. ULP-G and ULP-H immediately transferred R1 from the wheelchair to a recliner. ULP-G stated she had asked the RN to evaluate R1 for a different wheelchair, but she was unsure of the outcome. On September 9, 2021, at approximately 10:00 a.m., RN-A stated she believed additional 90 day assessments were completed for R1, but RN-A was unable to provide documentation of those additional assessments. At 10:15 a.m., RN-A confirmed she had not assessed R1 for the need for a different wheelchair stating, "I haven't looked into it." R3 - 90 DAY ASSESSMENT R3's 90-day reassessment did not include all the required elements on the uniform assessment tool. R3's diagnoses included, but were not limited to, hypertension (high blood pressure), dementia,	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 59	01620		

atrial fibrillation (an irregular, often rapid heart rate), and hyperlipidemia (high cholesterol).

R3's service plan dated December 16, 2020, indicated R3 received services which included medication administration, wound care, housekeeping, and assistance with bathing and grooming.

R3's record included a Monitoring and Reassessment for a 90-day visit dated September 2, 2021. This assessment indicated R3 required assistance with dressing, hygiene, bathing, incontinence care, housekeeping/laundry, and medication administration. This assessment did not include all the elements on the uniform assessment tool as required.

On September 8, 2021, at approximately 7:35 a.m., RN-B was observed providing direct care services, which included wound care to R3's right lower leg wound. At approximately 8:05 a.m., ULP-C was observed administering R3 his scheduled morning medications.

On September 9, 2021, at approximately 9:45 a.m., RN-A confirmed R3's 90-day reassessment did not include a review of all the required elements. RN-A verified the licensee had not implemented the uniform assessment tool for conducting resident assessments.

R4 - 90 DAY ASSESSMENT

R4's diagnoses included, but were not limited to, congested heart failure (CHF-a condition in which the heart's function as a pump is inadequate to meet the body's needs), dementia, and diabetes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 60 R4's service plan dated January 3, 2021, indicated R4 received services which included medication administration, wound care, assistance with bathing, grooming, dressing, incontinence care, and housekeeping/laundry. R4's record included a Monitoring and Reassessment for a 90-day visit dated April 17, 2021. There was no documentation of ongoing 90-day reassessments as required (53 days overdue). On September 8, 2021, at approximately 9:25 a.m., ULP-F was observed providing direct care services, which included medication administration. On September 9, 2021, at approximately 10:30 a.m., RN-A confirmed R4's reassessment had not been conducted within 90 days of the last reassessment as required. R8 - 90 DAY ASSESSMENT R8's diagnoses included, but were not limited to, diabetes, CHF, hypertension, and Parkinson's disease (a chronic progressive neurological disease which exhibits symptoms such as tremors, rigidity, impaired balance, slowness of movement and a shuffling gait). R8's service plan dated November 5, 2020, indicated R8 received services which included medication administration, assistance with bathing, dressing, incontinence care, and housekeeping/laundry. R8's Nurses Notes dated July 23, 2021, noted R8 fell out of bed and sent to urgent care as her right wrist was sore and swollen; a cast was applied.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 61 R8's Physician Orders dated July 23, 2021, indicated R8 had a right distal radial (wrist) fracture and would need to have a cast on for five weeks. R8's record included a Monitoring and Reassessment for a 90-day visit dated August 19, 2021. This assessment indicated R8 required assistance with dressing, hygiene, bathing, incontinence care, housekeeping/laundry, and medication administration. This assessment did not include all the elements on the uniform assessment tool as required, nor did this assessment include R8's change in condition related to her recent fall with injury. On September 8, 2021, at approximately 7:15 a.m., R8 was observed walking with a walker in the open dining room area. R8 had a cast on her right lower arm/wrist area. R8 stated she fell out of bed and broke her wrist a few weeks ago. On September 8, 2021, at approximately 1:30 p.m., RN-A confirmed R8's 90-day reassessment did not include a review of all the required elements including a review of the resident's change of condition regarding R8's fall with injury. The licensee's 6.01 Assessments, Reviews and Monitoring policy dated August 30, 2021, noted the initial nursing assessment or reassessment would include all of the elements of the uniform assessment tool as required. Resident reassessments and monitoring would be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessments and monitoring would be conducted as needed on changes in needs of the resident and cannot exceed 90 calendar days	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 62 from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=E	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure services plans were revised to reflect the current services provided for three of three residents (R1, R11,	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01640	Continued From page 63 and R13) reviewed. 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: R1 R1's record lacked documentation the service plan was revised each time a new service was added. R1's diagnoses included, but were not limited to, dementia, depression and anxiety. On September 8, 2021, at approximately 8:15 a.m., unlicensed personnel (ULP)-H was observed feeding R1. At approximately 8:20 a.m., ULP-G and ULP-H were observed transferring R1 from her wheelchair to a recliner with total assistance of two and a gait belt. ULP-G confirmed R1 transfers with two staff at all times. R1's service plan dated January 27, 2017, did not identify R1 received feeding and transfer assistance services. R11 R11's record lacked documentation the service plan was revised each time a new service was added. R11's diagnoses included, but were not limited to,	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01640	Continued From page 64	01640		

dementia, Parkinson's disease, anxiety, depression, and muscle weakness.

R11's service plan dated August 20, 2019, did not identify R11 received transfer assistance services.

On September 8, 2021, at approximately 7:45 a.m., R11 was observed being transferred from wheelchair to toilet and back to wheelchair with assistance of two staff, ULP-G and ULP-H.

R13
R13's record lacked documentation the service plan was revised each time a new service was added.

R13's diagnoses included, but were not limited to, dementia and arthritis.

R13's service plan dated April 9, 2018, did not identify R13 received transfer assistance services.

On September 8, 2021, at 6:45 a.m., R13 was observed being transferred from bed to wheelchair and then wheelchair to toilet and back during personal cares via total assistance of two staff, ULP-G and ULP-H.

On September 8, 2021, at 7:15 a.m., ULP-G stated almost all residents who resided in unit #3 required assistance of two staff to transfer.

On September 9, 2021, at 10:05 a.m., registered nurse (RN)-A was queried about the transfer status of residents residing in unit #3 and how staff knew how to transfer each resident. RN-A stated the resident transfer status was included in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01640	Continued From page 65 the ULP training. RN-A confirmed the dates R1, R11, and R13's last service plans were updated and stated services had not changed. On September 9, 2021, at 10:15 a.m., RN-B stated she believed R1, R11, and R13 could all transfer with assistance of one staff person. RN-B confirmed the service plans did not indicate transfer assistance as a provided service. The licensee's 6.08 Service Plan policy dated August 30, 2021, indicated service plans would be revised, if needed, based on resident assessments and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 66	01760		

by:
Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for two of four residents (R3, R10); and the licensee failed to ensure the steps of the medication administration process was followed for two of three employees (unlicensed personnel/ ULP-C, ULP-F) observed administering medications.

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:

MEDICATIONS NOT ADMINISTERED AS ORDERED/MEDICATION ERROR
R3
R3's diagnoses included, but were not limited to, hypertension (high blood pressure), dementia, atrial fibrillation (an irregular, often rapid heart rate), and hyperlipidemia (high cholesterol).

R3's service plan dated December 16, 2020, indicated the resident received services which included medication administration twice a day and as needed (PRN). R3's Medication/Treatment/Therapy/Management Plan dated March 2, 2021, indicated R3 received medication administration services and the resident's medications would be securely stored by the provider in the locked medication room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 67 which could only be accessed by staff. R3's prescriber orders dated December 15, 2020, included an order for Lopressor 25 milligrams (mg) (antihypertensive) to be administered twice a day. R3's prescriber orders dated January 13, 2021, included an order for Lorazepam 0.5 mg (a controlled substance that treats anxiety) to be administered every six hours PRN (as needed). On September 7, 2021, at approximately 2:50 p.m., the locked medication room in house #2 was reviewed with registered nurse (RN)-A. The following was observed and confirmed with RN-A: In the locked controlled substance box, one blister pack (a transparent, molded piece of plastic often sealed to a sheet of cardboard, used to package tablets) of Lorazepam 0.5 mg for R3 contained 27 tablets still sealed within the blister pack and one blister pack seal which had been broken and the seal taped back up on the back of the blister for tablet #28. The tablet in the blister labeled #28 appeared to be slightly different than the other tablets of Lorazepam which were still sealed in the blister pack. RN-A stated she would send the medication on to the pharmacy for review. On September 8, 2021, at approximately 6:55 a.m., RN-A confirmed the following: - the medication that had been resealed into blister #28 of R3's blister pack of Lorazepam was confirmed by pharmacy to be Lopressor 25 mg [not Lorazepam 0.5 mg] - RN-A conducted an investigation and determined through interviews that unlicensed personnel (ULP)-I admitted to inadvertently placing the Lopressor back into R3's Lorazepam blister pack. ULP-I verified this incident occurred on September 6, 2021. ULP-I explained that she	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 68	01760		

had initially planned to administer a PRN dose of Lorazepam to R3 along with his 8:00 p.m. medications as the resident was anxious. However, after she had prepared R3's scheduled 8:00 p.m., medications which included a dose of PRN Lorazepam, R3 had calmed down so ULP-I decided to not administer the PRN Lorazepam. ULP-I removed what she thought to be the dose of Lorazepam from the prepared medications and placed it back in the Lorazepam blister pack under blister #28 and placed tape across the seal on the back.
RN-A confirmed this would be considered a medication error as the scheduled 8:00 p.m. dose of Lopressor 25 mg was omitted and R3 inadvertently received a dose of Lorazepam 0.5 mg instead.

R10
R10's diagnoses included, but were not limited to, dementia, anxiety, schizoaffective disorder, diabetes and asthma.

R10's service plan dated January 8, 2017, indicated the resident received services which included medication administration four times a day and PRN. R10's Medication/Treatment/Therapy/Management Plan dated November 10, 2016, indicated R9 received medication administration services and specific parameters regarding medications were located on the client Medication Administration Record (MAR).

R10's prescriber orders dated June 8, 2021, included an order for Syntrhoid 137 micrograms (mcg) by mouth daily 30 minutes before food and other medications.

On September 8, 2021, at approximately 8:10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 69	01760		

a.m., ULP-G was observed to administer R10's scheduled morning medications, including Syntrhoid, while R10 was eating breakfast. The MAR did include instructions to administer the Syntrhoid 30 minutes before food and other medications.

On September 9, 2021, at 9:15 a.m., RN-B confirmed it was the facility's procedure for Synthroid to be given 30 minutes prior to a meal and instructions should be in the MAR.

PROCESS OF MEDICATION ADMINISTRATION ULP-C
Medications for R3 were documented by ULP-C as being administered prior to the medications being administered.

As noted above R3's service plan dated December 16, 2020, indicated the resident received services which included medication administration twice a day and as needed (PRN).

During a medication pass observation for R3 with ULP-C on September 8, 2021, at approximately 8:05 a.m. the following was observed:
- ULP-C removed from the locked medication room R3's scheduled 8:00 a.m. medications from the preset blister packs
- ULP-C placed the medications into a medication cup and counted the medications
- ULP-C checked the MAR and initialed R3's MAR by each medication she had prepared indicating the medication had been administered
- ULP-C then approached R3 who was seated at a table in the dining room and completed the medication pass.

Directly following the above medication pass observation, ULP-C verified she had documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 70 R3's medications as being administered prior to the medications actually being administered. ULP-C stated she should have documented in the MAR after R3 had taken his medications. ULP-F Medications for R5 were documented by ULP-F as being administered prior to the medications being administered. R5's diagnoses included, but were not limited to, diabetes, dementia, and asthma. R5's service plan dated March 8, 2021, indicated the resident received services which included medication administration three times a day and PRN. During a medication pass observation for R5 with ULP-F on September 8, 2021, at approximately 8:20 a.m. the following was observed: - ULP-F removed from the locked medication room R5's Incruse Ellipta 62.5 mg inhaler (a medication that relaxes the muscles in the airways to improve breathing) - ULP-F approached R5 who was seated at a table in the dining room and instructed the resident to use the inhaler - following administration of R5's inhaler, ULP-F proceeded to return the inhaler back to the medication room, ULP-F was asked about when she was going to document the administration of R5's inhaler. ULP-F responded she had documented R5's inhaler as being administered prior to the medication being administered. ULP-F stated she knew medications should be signed off directly after they are administered and not before.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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 71 On September 9, 2021, at approximately 9:15 a.m., RN-B confirmed all medications should be signed off on the resident's MAR after they have been administered. The licensee's 7.35 Inhaler policy dated August 30, 2021, indicated the last step in the administration process was to document the medication administration in the resident's record. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated August 30, 2021, noted the RN would ensure ULPs were instructed in the proper methods with respect to each resident to administer medications; specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and communicated wit the ULP about the individual needs of the resident. In addition, the policy noted documentation of medication administration would occur after the medication was administered and observed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by:	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01770	Continued From page 72 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 (R4) with records reviewed This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 7, 2021, at approximately 2:05 p.m., registered nurse (RN)-A confirmed the licensee provided medication management services which included medication setup by the RN for one resident R4. R4's record lacked documentation by the licensed nurse at the time of medication setup to include: documentation of the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration and the name of the person completing medication setup. R4's diagnoses included, but were not limited to, diabetes, dementia, stroke, and congested heart failure (CHF- a condition in which the heart's function as a pump is inadequate to meet the body's needs). R4's Medication/Treatment/Therapy Management Plan dated January 3, 2021, and Monitoring and	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01770	Continued From page 73 Reassessment dated January 17, 2021, indicated the resident received medication management services to include medication setup. R4's prescriber orders dated June 14, 2021, included but were not limited to, one antihypertensive, one blood thinner, one diuretic, one oral anti-diabetic medication, and three vitamin/mineral supplements. On September 8, 2021, at approximately 9:25 a.m., unlicensed personnel (ULP)-F was observed to conduct a medication pass for R4, which included administration of seven (7) medications from a preset bubble pack (a transparent molded piece of plastic often sealed to a sheet of cardboard, used to package tablets). At the top on the left-hand side of the bubble pack package was a handwritten signature for RN-A along with a date of September 3, 2021. R4's record lacked documentation for 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 the name of the person completing medication setup as required. On September 8, 2021, at approximately 1:40 p.m., RN-A verified R4 received weekly medication setup services by the RN. RN-A stated she signs and dates the bubble pack package when she sets the medications up for the resident. RN-A verified R4's medication setup was not documented in R4's record to include the required content noted above. The licensee's 7.08 Medication Management -Administration and Setup policy dated August 30, 2021, noted a licensed nurse would correctly and	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01770	Continued From page 74 accurately document any medication setup provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01940	Continued From page 75 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Surveyor: Chenze, Jessica Based on interview and record review, the licensee failed to ensure treatments or therapies were administered as prescribed, and to document the reason they were not provided to meet the resident's needs with blood glucose monitoring managed by the provider for one of one resident (R2) reviewed. 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 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, but were not limited to, Type II diabetes mellitus, hypertension, depression and anxiety. R2's service plan dated August 31, 2021, indicated R2 received services which included medication administration, weekly vitals signs and monthly weight monitoring, assistance with bathing and grooming, as well as assistance with dressing and continence care. R2's service plan did not contain a written statement for the treatment services being provided, which included blood glucose monitoring. R2's prescriber orders dated September 3, 2021, included an order for blood glucose checks twice	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01940	Continued From page 76 daily. During the entrance conference on September 7, 2021, at approximately 2:10 p.m., registered nurse (RN)-A confirmed the licensee provided treatment and therapy services to residents as prescribed. On September 8, 2021, at approximately 8:30 a.m., unlicensed personnel (ULP)-G was observed checking R2's blood glucose and then document the result. On September 9, 2021, at approximately 9:55 a.m., RN-B confirmed R2's service plan did not contain a written statement of treatment services that included blood glucose monitoring. The licensee's 7.05 Treatment & Therapy Management Plan policy dated August 30, 2021, indicated each resident record must contain a statement of the type of services that will be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01950	Continued From page 77	01950		

assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:
(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;
(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and
(3) communicated with the unlicensed personnel about the individual needs of the resident.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of one resident receiving blood glucose monitoring (R2) with records reviewed.

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 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
R2's diagnoses included, but were not limited to, type II diabetes mellitus, hypertension,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01950	Continued From page 78 depression and anxiety. R2's service plan dated August 31, 2021, indicated the resident received services which included medication administration, weekly vitals signs and monthly weight monitoring, assistance with bathing and grooming, as well as assistance with dressing and continence care. On September 8, 2021, at approximately 8:30 a.m., unlicensed personnel (ULP)-G was observed to check R2's blood glucose and then document the result. ULP-G confirmed R2's Vital Signs form lacked blood glucose parameters for when to notify the RN with low or elevated blood glucose results, or other instructions related to blood glucose results. ULP-G stated she was uncertain when she would need to notify the RN with results. On September 9, 2021, at approximately 9:45 a.m., RN-A confirmed R2's record lacked blood glucose parameters and would need to obtain from R2's primary care provider. The licensee's 7.05 Treatment & Therapy Management Plan policy dated August 30, 2021, indicated the resident record must contain documentation of specific resident instructions relating to the treatments or therapy administration as well as procedures for notifying a registered nurse when a problem arose with treatments or therapy services and any resident specific requirements relating to documentation of treatment and therapy received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure treatments or therapies were administered as prescribed, or to document the reason they were not provided to meet the resident's needs for one of one resident (R2) with blood glucose (sugar) monitoring managed by the provider. 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 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, but were not limited to, type II diabetes mellitus, hypertension,	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01960	Continued From page 80 depression and anxiety. R2's service plan dated August 31, 2021, indicated the resident received services which included medication administration, weekly vitals signs and monthly weight monitoring, assistance with bathing and grooming, as well as assistance with dressing and continence care. On September 8, 2021, at approximately 8:30 a.m., unlicensed personnel (ULP)-G was observed to check R2's blood glucose and then document the result. ULP-G confirmed R2's Vital Signs form lacked blood glucose results for September 4, 5, and 6, 2021. ULP-G stated she could go back in the blood glucose monitor to review the dates to verify if a blood glucose had been taken. ULP-G retrieved the results for September 6, 2021, and documented the result on the Vital Signs form. On September 9, 2021, at approximately 9:45 a.m., registered nurse (RN)-A stated she believed staff had missed R2's blood glucose monitoring on the dates above. The licensee's 7.22 Medication & Treatment Record - Documentation & Refusal policy dated August 30, 2021, indicated documentation of treatments would be completed by the person who performed the task immediately after the assistance/administration was completed. In addition, the policy noted if a treatment was refused, it would be indicated on the Treatment Administration Record (TAR) by circling your initials and writing a capital R in the same box on the TAR. No further information was provided.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
01960	Continued From page 81 TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide a hazard vulnerability assessment for the facility. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: While reviewing records on September 8, 2021, between 9:45 a.m. and 1:15 p.m., the facility provided a completed hazard vulnerability	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02040	Continued From page 82 assessment for the new building across the street located at 511 Iron Drive in Chisholm. Each location is required to have a hazard vulnerability assessment or safety risk performed on and around the property. The following observations were made: -the facility failed to provide a hazard vulnerability assessment or safety risk for the location; -gate style doors separating the kitchens from resident dining areas in all three houses were not secure, as the doors were provided with sliding latches which did not lock. Cooking ranges were not disconnected during times when the kitchen was not staffed; and -laundry room door was open in House 3 and not staffed during facility tour. On September 8, 2021, at approximately 1:30 p.m., office manager-J and owner-K confirmed the facility failed to provided a hazard vulnerability assessment for the facility. A policy was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02070 SS=F	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by:	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02070	Continued From page 83 Based on observation, interview, and record review, the licensee failed to ensue one or more persons were available 24 hours a day, seven days a week who where responsible for responding to requests of residents for assistance. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 31 residents. The licensee did not ensure that one or more staff were always available during the night shift in each secured house on the campus. On September 7, 2021, at approximately 2:30 p.m., during the initial tour of the facility with registered nurse (RN)-A it was observed the facility consisted of three (3) separate unattached secure units (houses) which all opened to a common enclosed courtyard. Each secure unit had a capacity to house a total of ten to eleven residents. The current census at the facility was 29 residents. On September 8, 2021, at approximately 5:55 a.m., unlicensed personnel (ULP)-D confirmed she worked the night shift, and the regular	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02070	Continued From page 84 staffing pattern was to have one ULP in each house for a total of three staff. ULP-D stated if another ULP needed assistance with a resident in a different house she would leave her house unattended to go and assist the ULP. ULP-D verified she could be gone for up to 15 minutes especially if a resident needed to be changed. On September 8, 2021, at approximately 7:15 a.m., ULP-G confirmed a majority of the residents in unit #3 required assistance of two staff to transfer. ULP-G stated she was told by night shift staff if a resident needed to be transfered during the night, a staff member would leave another unit to assist. On September 9, 2021, at approximately 9:20 a.m., RN-A confirmed the daily staffing pattern for the night shift (10:00 p.m., until 6:00 a.m.) was one ULP per house, for a total of three ULP routinely scheduled for the night shift. RN-A confirmed the staff were supposed to call or text herself if they need assistance during the night and they were never to leave their assigned house unattended. RN-A stated the licensee did not have a written procedure to reflect this practice. The licensee's 3.09 ALDC (Assisted Living Dementia Care) Physical Environment, Fire Protection and Staffing policy dated August 30, 2021, noted an awake staff person would be physically present within the secured unit at all times. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02090	Continued From page 85	02090		
02090 SS=D	144G.82 Subdivision 1 General The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a dignified dining experience for one of two residents (R12) with records reviewed. 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 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: R12's diagnoses included, but were not limited to, cognitive deficits, schizophrenia and bilateral foot drop (inability to raise the front of the foot due to weakness or paralysis). R12's service plan dated January 22, 2019, indicated the resident received the following services: medication administration, assistance with dressing, continence, bathing and grooming, as well as food preparation.	02090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02090	Continued From page 86 On September 8, 2021, at 8:00 a.m., unlicensed personnel (ULP)-H was observed to prepare and serve sliced banana and hot cereal to R12. R12's sliced banana was placed in front of her and the hot cereal in a bowl in the middle of the table. ULP-H began feeding another resident at the table. At 8:15 a.m., ULP-H left the table to assist another resident; R12's hot cereal remained in the middle of the table, out of R12's reach. On September 8, 2021, during continuous observation from 8:15 a.m. to 8:40 a.m., R12's hot cereal remained in the middle of the table. At 8:40 a.m., ULP-H was observed to place R12's hot cereal in front of R12 and began to assist R12 with feeding. ULP-H did not offer to warm up the hot cereal or ask R12 if the temperature of the hot cereal was okay. On September 9, 2021, at 10:10 a.m., registered nurse (RN)-A stated it was her expectation R12 would be given her food and allowed to eat immediately after serving. RN-A identified R12 as a resident who did not require feeding assistance. The licensee's 12.01 Food Service & Menu Planning policy dated August 30, 2021, indicated residents had the right to access food at any time and the facility would not restrict access to food unless certain circumstances were necessary for the resident's health and safety and documented in the resident's record. The licensee's 12.02 Dining Service policy dated August 30, 2021, indicated residents may be seated as early as five minutes prior to the starting time of a meal. No further information was provided.	02090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02090	Continued From page 87 TIME PERIOD FOR CORRECTION: Seven (7) days	02090		
02110 SS=D	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02110	Continued From page 88 to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care were provided to residents and the residents legal and designated representatives at the time of move-in for one of one resident (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's record lacked evidence R2 and/or R2's legal and designated representative were provided the facility's policies and procedures related to assisted living with dementia care, as required. R2 was admitted for services on August 31, 2021, to the facility licensed as an assisted living with dementia care. R2's diagnoses included, but were not limited to, diabetes type II, hypertension (high blood pressure), depression and anxiety. R2's service plan dated August 31, 2021, indicated the resident received services which included medication administration, bathing, dressing, grooming, and incontinence care services, and weekly vital signs and monthly	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02110	Continued From page 89 weight monitoring, as well as daily activities. On September 8, 2021, at approximately 8:30 a.m., unlicensed personnel (ULP)-G was observed to check R2's blood glucose level. On September 9, 2021, at 10:00 a.m., registered nurse (RN)-A confirmed the required policies and procedures had not been provided to R2 or R2's legal and designated representative at time of move-in. The licensee's 3.00 Assisted Living with Dementia Care Additional Required Policies policy dated August 30, 2021, indicated the following policies and procedures must be provided to residents and the residents' legal and designated representatives at time of move-in: -Philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; -Evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; -Wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -Medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; -Staff training specific to dementia care; -Description of life enrichment programs and how activities are implemented; -Description of family support programs and efforts to keep the family engaged; -Limiting the use of public address and intercom systems for emergencies and evacuation drills	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02110	Continued From page 90 only; -Transportation coordination and assistance to and from outside medical appointments; and -Safekeeping of residents' possessions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02170	Continued From page 91 that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have an evaulation for an activity plan for three of three residents (R1, R2, R3) who resided in the secure dementia care unit. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had a current assisted living with dementia care license. R1 R1's diagnoses included, but were not limited to, dementia, depression and anxiety. R1's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following:	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02170	Continued From page 92 - past and current interests - current abilities and skills - emotional and social needs and patterns - physical abilities and limitations - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions In addition, R1's record lacked the development of an individualized activity plan. R2 R2's diagnoses included, but were not limited to, type II diabetes mellitus, hypertension, depression and anxiety. R2's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests - current abilities and skills - emotional and social needs and patterns - physical abilities and limitations - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions In addition, R2's record lacked the development of an individualized activity plan. R3 R3's diagnoses included, but were not limited to, hypertension (high blood pressure), dementia, atrial fibrillation (an irregular, often rapid heart rate), and hyperlipidemia (high cholesterol). R3's record lacked evidence that the resident had	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02170	Continued From page 93 been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests - current abilities and skills - emotional and social needs and patterns - physical abilities and limitations - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions In addition, R3's record lacked the development of an individualized activity plan. On September 8, 2021, at approximately 9:35 a.m., registered nurse (RN)-A confirmed activity evaluations and individualized activity plans had not been completed for R1, R2, R3, and all other residents at the facility as required. The licensee's 3.05 ALDC (assisted living dementia care) Life Enrichment Programs, Activities and Outdoor Space policy dated August 30.2010, noted each resident would be evaluated for activities and an individualized activity plan would be developed for each resident based on their activity evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02240 SS=F	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02240	Continued From page 94 section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained.	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02240	Continued From page 95 Acknowledgment of receipt shall be retained 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 current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for three of three residents (R1, R2, and R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The license had a current assisted living with dementia care license. R1 R1's diagnoses included, but were not limited to, dementia, depression and anxiety. R1's service plan, dated January 27, 2017, indicated the resident received services which included medication administration and assistance with bathing, grooming and dressing. On September 8, 2021, at approximately 8:15 a.m., unlicensed personnel (ULP)-H was observed to provide feeding assistance to R1.	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02240	Continued From page 96 R1's record included an undated copy of the Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers dated November 2019. R2 R2's diagnoses included, but were not limited to, type II diabetes mellitus, hypertension, depression and anxiety. R2's service plan dated August 31, 2021, indicated the resident received services which included medication administration, weekly vitals signs and monthly weight monitoring, assistance with bathing and grooming, as well as assistance with dressing and continence care. R2's Home Care Bill of Rights Acknowledgement Form dated August 31, 2021, indicated R1 had received a copy of the Home Care Bill of Rights and included a copy of the Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers dated November 2019. R3 R3's diagnoses included, but were not limited to, hypertension (high blood pressure), dementia, atrial fibrillation (an irregular, often rapid heart rate), and hyperlipidemia (high cholesterol). On September 8, 2021, at approximately 7:35 a.m., Registered Nurse (RN)-B was observed to provide wound care to R3's lower right leg wound. At approximately 8:05 a.m., ULP-C was observed to administer R3 his scheduled morning medications. R3's Home Care Bill of Rights Acknowledgement	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02240	Continued From page 97 Form dated December 16, 2020, indicated R3 had received a copy of the Home Care Bill of Rights and included a copy of the Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers dated November 2019. On September 9, 2021, at approximately 9:50 a.m., RN-A verified R1, R2, R3, and all other residents at the facility had not received the current Minnesota Bill of Rights for Assisted Living Residents dated May 16, 2021, as required. The licensee's 2.05 Bill of Rights policy dated August 30, 2021, noted the licensee would provide the resident or the resident's representative a written copy of the Assisted Living Bill of Rights before the date that services were first initiated. The licensee would obtain written acknowledgement of the resident's receipt of the bill of rights and acknowledgement of this receipt would be retained in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02410	Continued From page 98 otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of three residents (R7, R8) was treated with respect and dignity related to privacy. 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: R7 and R8's blood glucose (sugar) monitoring procedure was performed while seated in the	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02410	Continued From page 99 occupied dining room. R7 R7's prescriber orders dated July 26, 2021, included an order for blood glucose monitoring to be completed daily. On September 8, 2021, at approximately 7:55 a.m., R7 was seated at the dining room table in the open dining/living room area. There were four other residents seated at the tables in the dining room. Unlicensed personnel (ULP)-C approached R7 and following appropriate technique, lanced the resident's finger, obtained a blood sample on the test strip. ULP-C conducted this blood glucose monitoring procedure in direct view of the four other residents in the dining room area. ULP-C did not encourage, offer, or attempt to assist the resident to a private area to perform the blood glucose check. R8 R8's prescriber orders dated November 25, 2020, included an order for blood glucose monitoring to be completed twice daily. On September 8, 2021, at approximately 8:00 a.m., R8 was seated at the dining room table in the open dining/living room area. There were three other residents seated at the tables in the dining room. ULP-C approached R8 and following appropriate technique, lanced the resident's finger, obtained a blood sample on the test strip. ULP-C conducted this blood glucose monitoring procedure in direct view of the three other residents in the dining room area. ULP-C did not encourage, offer, or attempt to assist the resident to a private area to perform the blood glucose check.	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
02410	Continued From page 100 Directly following the above two observations, ULP-C confirmed she had not provided R7 or R8 privacy when conducting their blood glucose checks. On September 8, 2021, at approximately 9:05 a.m., registered nurse (RN)-A confirmed blood glucose monitoring procedures should be done in private and not in view of other residents. The licensee's 7.31 Blood Sugar Testing policy dated August 30, 2021, outlined the steps for conducting the blood glucose monitoring procedure, however, did not include verbiage regarding providing privacy during the procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required notice was posted at the main entry way of the	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	504 IRON DRIVE CHISHOLM, MN 55719

(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
03090	Continued From page 101 facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff and any visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 7, 2021, at 1:40 p.m., the main entry way of the establishment was observed with no signage, as required, to notify visitors of electronic monitoring. On September 7, 2021, at 3:30 p.m., registered nurse (RN)-A confirmed the common areas of the facility had cameras, but stated the cameras did not record and was in real time with no audio. RN-A stated residents were notified of the cameras, and cameras were not present in resident rooms. RN-A verified the required signage was not posted at the main entry way of the facility and was unaware of the requirement. The licensee's 2.15 Electronic Monitoring policy, dated September 7, 2021, indicated signs would be installed at each facility entrance accessible to visitors that stated: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30680	A. BUILDING: _____ B. WING _____	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ASSISTED LIVING	**504 IRON DRIVE CHISHOLM, MN 55719**

(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
03090	Continued From page 102 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

DEPARTMENT OF HEALTH

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

Type: Full
Date: *09/07/21*
Time: 09:45:00
Report: 7983211138

Food and Beverage Establishment Inspection Report

Location:
Aspen Grove Assisted Living #1
504 Iron Drive
Chisholm, MN55719
St. Louis County, 69

Establishment Info:
ID #: N000204
Risk: Medium
Announced Inspection: Yes

License Categories:

Expires on: 12/31/21

Operator:
Charles Gargano
Phone #: (218)254-275
ID #:

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

The following orders were issued during this inspection.

3-500A Microbial Control: cooling

3-501.14A ***** Priority 1 *****

MN Rule 4626.0385A Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.

MACARONI & CHEESE IN THE FRIGIDAIRE SINGLE-DOOR UPRIGHT REFRIGERATOR WAS 43 F. OTHER ITEMS IN THIS UNIT WERE 40-41 F. DISCUSSED COOLING REQUIREMENT AND EQUIPMENT REQUIREMENT [MN RULES 4626.05.06 (G)]. IT WAS DISCARDED.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

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

A METHOD TO MEASURE THE SURFACE TEMPERATURE OF UTENSILS THAT ARE CLEANED AND SANITIZED IN THE WAREWASHING MACHINE WAS NOT PROVIDED.

Comply By: 09/21/21

2-100 Supervision

2-102.12AMN

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

A CERTIFIED FOOD PROTECTION MANAGER (CFPM) WAS NOT EMPLOYED. THE PROPOSED CFPM HAS TAKEN TWO MODULES OF AN ONLINE COURSE.

Comply By: 10/07/21

Food and Beverage Establishment Inspection Report

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

SOME TCS FOODS ARE COOKED THE DAY BEFORE SERVICE. DISCUSSED COOKING TCS FOODS THE DAY OF SERVICE AND NOT KEEPING LEFTOVERS.

Comply By: 09/07/21

Food and Equipment Temperatures

Process/Item: Cooling
Temperature: 43 Degrees Fahrenheit - Location: Macaroni & cheese in the Frigidaire single-door upright refrigerator.
Violation Issued: Yes

Process/Item: Upright Refrigerator
Temperature: 41 Degrees Fahrenheit - Location: Butter in the Frigidaire single-door upright refrigerator.
Violation Issued: No

Process/Item: Upright Refrigerator
Temperature: 40 Degrees Fahrenheit - Location: Country Crock in the Frigidaire single-door upright refrigerator.
Violation Issued: No

Process/Item: Upright Refrigerator
Temperature: 31 Degrees Fahrenheit - Location: Meatballs in the Frigidaire single-door upright refrigerator.

Violation Issued: No

Process/Item: Upright Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the Frigidaire single-door upright freezer was frozen solid.
Violation Issued: No

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

==========

GENERAL COMMENTS:

1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed, cooling, and equipment requirements

==========

Type: Full
Date: *09/07/21*
Time: 09:45:00
Report: 7983211138
Aspen Grove Assisted Living #1

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 7983211138 of 09/07/21.

Certified Food Protection Manager: Charles Gargano

Certification Number: Pending Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____

Charles Gargano
Owner

Signed: 7983

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

Report #: 7983211138

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	2	Date	09/07/21
No. of Repeat RF/PHI Categories Out	0	Time In	09:45:00
Legal Authority MN Rules Chapter 4626		Time Out	

Establishment	Address	City/State	Zip Code	Telephone
Aspen Grove Assisted Living #1	504 Iron Drive	Chisholm, MN	55719	(218)254-275

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
N000204	Charles Gargano	Full		M

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 09/07/21

Inspector (Signature) 7983

DEPARTMENT OF HEALTH

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

Type: Full
Date: *09/07/21*
Time: 09:45:00
Report: 7983211139

Food and Beverage Establishment Inspection Report

Location:
Aspen Grove Assisted Living #2
504 Iron Drive
Chisholm, MN55719
St. Louis County, 69

Establishment Info:
ID #: N000205
Risk: Medium
Announced Inspection: Yes

License Categories:

Expires on: 12/31/21

Operator:
Charles Gargano
Phone #: (218)259-170
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

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

A METHOD TO MEASURE THE SURFACE TEMPERATURE OF UTENSILS THAT ARE CLEANED AND SANITIZED IN THE WAREWASHING MACHINE WAS NOT PROVIDED.

Comply By: 09/21/21

2-100 Supervision

2-102.12AMN

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

A CERTIFIED FOOD PROTECTION MANAGER (CFPM) WAS NOT EMPLOYED. THE PROPOSED CFPM HAS TAKEN TWO MODULES OF AN ONLINE COURSE.

Comply By: 10/07/21

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

SOME TCS FOODS ARE COOKED THE DAY BEFORE SERVICE. DISCUSSED COOKING TCS FOODS THE DAY OF SERVICE AND NOT KEEPING LEFTOVERS.

Comply By: 09/07/21

Food and Equipment Temperatures

Type: Full
Date: *09/07/21*
Time: 09:45:00
Report: 7983211139
Aspen Grove Assisted Living #2

Food and Beverage Establishment Inspection Report

Process/Item: Upright Refrigerator
Temperature: 38 Degrees Fahrenheit - Location: Raw shell egg in the Aurora single-door upright refrigerator.

Violation Issued: No

Process/Item: Upright Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the Frigidaire single-door upright freezer was frozen solid.
Violation Issued: No

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

GENERAL COMMENTS:

1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed, cooling, and equipment requirements.

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 7983211139 of 09/07/21.

Certified Food Protection Manager Charles Gargano

Certification Number: Pending Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____ Signed: 7983

Charles Gargano
Owner

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

Report #: 7983211139

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	1	Date	09/07/21
No. of Repeat RF/PHI Categories Out	0	Time In	09:45:00
Legal Authority MN Rules Chapter 4626		Time Out	

Establishment	Address	City/State	Zip Code	Telephone
Aspen Grove Assisted Living #2	504 Iron Drive	Chisholm, MN	55719	(218)259-170

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
N000205	Charles Gargano	Full		M

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 09/07/21

Inspector (Signature) 7983

DEPARTMENT OF HEALTH

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

Type: Full
Date: *09/07/21*
Time: 09:45:00
Report: 7983211140

Food and Beverage Establishment Inspection Report

Location:
Aspen Grove Assisted Living #3
504 Iron Drive
Chisholm, MN55719
St. Louis County, 69

Establishment Info:
ID #: N000206
Risk: Medium
Announced Inspection: Yes

License Categories:

Expires on: 12/31/21

Operator:
Charles Gargano
Phone #: (218)254-275
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

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

A METHOD TO MEASURE THE SURFACE TEMPERATURE OF UTENSILS THAT ARE CLEANED AND SANITIZED IN THE WAREWASHING MACHINE WAS NOT PROVIDED.

Comply By: 09/21/21

2-100 Supervision

2-102.12AMN

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

A CERTIFIED FOOD PROTECTION MANAGER (CFPM) WAS NOT EMPLOYED. THE PROPOSED CFPM HAS TAKEN TWO MODULES OF AN ONLINE COURSE.

Comply By: 10/07/21

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

SOME TCS FOODS ARE COOKED THE DAY BEFORE SERVICE. DISCUSSED COOKING TCS FOODS THE DAY OF SERVICE AND NOT KEEPING LEFTOVERS.

Comply By: 09/07/21

Food and Equipment Temperatures

Type: Full
Date: *09/07/21*
Time: 09:45:00
Report: 7983211140
Aspen Grove Assisted Living #3

Food and Beverage Establishment Inspection Report

Process/Item: Upright Refrigerator
Temperature: 39 Degrees Fahrenheit - Location: Milk in the Aurora single-door upright refrigerator.
Violation Issued: No

Process/Item: Upright Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the Danby single-door upright freezer was frozen solid.
Violation Issued: No

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

GENERAL COMMENTS:

1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed, cooling, and equipment requirements.

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 7983211140 of 09/07/21.

Certified Food Protection Manager Charles Gargano

Certification Number: Pending Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____ Signed: 7983

Charles Gargano
Owner

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

Report #: 7983211140

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	1	Date	09/07/21
No. of Repeat RF/PHI Categories Out	0	Time In	09:45:00
Legal Authority MN Rules Chapter 4626		Time Out	

Aspen Grove Assisted Living #3	Address: 504 Iron Drive	City/State: Chisholm, MN	Zip Code: 55719	Telephone: (218)254-275
License/Permit #: N000206	Permit Holder: Charles Gargano	Purpose of Inspection: Full	Est Type:	Risk Category: M

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 09/07/21

Inspector (Signature) 7983