DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 19, 2023

Licensee
The Encore At Mahtomedi
720 Mahtomedi Avenue
Mahtomedi, MN 55115

RE: Project Number(s) SL28353015

Dear Licensee:

On April 19, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 19, 2023 survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

Electronically Delivered

March 1, 2023

Licensee
The Encore at Mahtomedi
720 Mahtomedi Avenue
Mahtomedi, MN 55115

RE: Project Number(s) SL28353015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 19, 2023, 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.

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

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

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

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), 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
St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - $3,000.00
St - 0 - 1640 - 144g.70 Subd. 4 (a-E) - Service Plan, Implementation And Revisions To - $3,000.00
St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00

The total amount you are assessed is $9,500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in 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,

Jess Schoenecker, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jess.Schoenecker@state.mn.us
Phone: 651-201-3789 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28353	A. BUILDING: _____ B. WING _____	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCORE AT MAHTOMEDI	720 MAHTOMEDI AVENUE MAHTOMEDI, MN 55115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28353015 On, January 17, through January 19, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 34 residents whom received services under the provider's Assisted Living with Dementia Care license. On January 18 and January 19, 2023, immediate orders were issued for 1620, 1640, and 2070, respectively. The immediacy was not removed by the time of exit on January 19, 2023.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility with dementia care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated January 18, 2023, for the specific Minnesota Food Code deficiencies. 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.	0 510		

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0 510	Continued From page 2 (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 establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect all staff, residents and visitors.) The findings include: On January 18, 2023, at approximately 7:45 a.m., unlicensed personnel (ULP)-D entered R2's room to provide medication administration and perform a blood glucose test on R2. ULP-D failed to perform hand hygiene prior to entering R2's room, and prior to donning (putting on) gloves. ULP-D failed to perform doffing (taking off) gloves and hand hygiene after performing blood glucose testing on R2. ULP-D continued to wear	0 510		

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0 510	Continued From page 3 contaminated gloves and proceeded to the facility's medication room touching the entry keypad, medication cart, and medication packets while setting up medications for another resident's medication pass. ULP-D performed doffing and donning before providing a medication pass for another resident, but failed to perform hand hygiene prior to donning gloves. The licensee's Standard (Universal Precautions) for 2.46 Infection Control policy dated December 2021, indicated staff would perform hand hygiene between all patient contact and before and after use of gloves. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by:	0 580		

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0 580	Continued From page 4 Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management (QM) activities relevant to the size and services provided by the assisted living provider. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 17, 2023, at 10:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she knew "right off the bat," they were not in compliance with QM. LALD/RN-A stated they had no documentation to provide. The licensee's Quality Management Program policy dated July 2021, indicated, "[The licensee] will have at least one documented quality management project in place at all times, and retain records of such projects for at least two years." Further, "Document the quality management process on form 1.22MN-F Quality Management Minutes; keep all related documents on file for at least two years." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 580		

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0 580	Continued From page 5 (21) days	0 580		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required annual performance reviews for one of two employees (licensed practical nurse (LPN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650		

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0 650	Continued From page 6 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: LPN-B began employment with the licensee on October 1, 2019. LPN-B's employee record lacked current annual performance reviews. LPN-B's employee record included one annual performance review dated October 5, 2020. On January 18, 2023, at 11:26 a.m., LPN-B stated she was unsure if they had completed annual performance reviews for her. On January 18, 2023, at 11:26 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated there were no additional annual performance reviews for LPN-B. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	0 660		

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0 660	Continued From page 7 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a history and symptom screening result for two of two employees (licensed practical nurse (LPN)-B, unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: LPN-B LPN-B began employment with the licensee on October 1, 2019. LPN-B's employee record included the Annual TB Screening Tool for Healthcare Workers (HCWs)	0 660		

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0 660	Continued From page 8 forms dated, March 11, 2020, and March 18, 2021, but lacked documented evidence of required TB screening by blood test or tuberculin skin testing (TST). ULP-D ULP-D began employment with the licensee on August 15, 2022. ULP-D's employee record included an undated Baseline Screening Tool for Healthcare Personnel (HCPs) which indicated ULP-D completed TB history screening but lacked documented evidence of required TB screening by blood test or TST. On January 17, 2023, at 1:30 p.m., Administrator (A)-C stated during a staffing transition period, the licensee experienced a period when TB testing was failed to be performed, and the licensee had initiated audits to identify staff who needed TB testing. On January 18, 2023, at 11:26 a.m., LPN-B stated her TB test was done, but was unsure where the documentation was. On January 18, 2023, at 11:26 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated their branch office already sent over all of LPN-B's record and TB testing documentation was not there. LALD/RN-A stated if the surveyors continued searching through more employee records, they would find many more missing TB test results. The licensee's 2.02MN Tuberculosis (TB) Screening policy dated February 2022, indicated each staff person at time of hire and prior to any contact with residents would be screened for TB.	0 660		

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0 660	Continued From page 9 The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents.	0 680		

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0 680	Continued From page 10 (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 17, 2023, at approximately 11:30 a.m., administrator (A)-C provided a binder and indicated the contents were the licensee's EP plan. The licensee's EP plan lacked: -risk assessments; -annual updates; -patient population;	0 680		

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0 680	Continued From page 11 -EP collaboration; -EP policies and procedures (P/P) based on the risk assessment and communication plan; -subsistence needs for staff and patients; -procedures for tracking staff and patients; -P/P including evacuation, sheltering, medical documents, and volunteers; -development of communication plan; -names and contact information; -family notifications; and -emergency prep training and testing as required by Appendix Z. On January17, 2023, at approximately 1:00 p.m., A-C acknowledged the licensee's emergency preparedness plan lacked the above listed required content. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require	0 730		

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0 730	Continued From page 12 documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of all services provided for one of one resident (R1).	0 730		

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0 730	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: R1's service agreement dated December 14, 2022, indicated R1 received services for grooming, medication management, bathing, bathroom assistance, mobility, transfers, meals/dining, and behavior management. R1's service log for November and December 2022, lacked documentation for most services provided on the following dates: - November 1 through 30, 2022; and - December 1 through 31, 2022. On January 18, 2023, at 12:25 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the empty spaces on the service log should not be there, there should always be something documented even if the resident refused. The licensee's Documentation Requirements in Resident Records policy dated May 2022, indicated, "-Staff will document, on a daily basis, medications, services, treatments or therapies provided to resident; - All documentation must include the signature and title of the person who performed the service or administered the medication, treatment, or therapy. Initials may be used if there is a	0 730		

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0 730	Continued From page 14 completed signature page included in the documentation; - For medications administered or treatments and/or therapies administered, documentation in a resident ' s chart must include the date and time of the administration; - When medications, services, treatments, or therapies or not performed per the service agreement and schedule, staff must document the reason why it was not performed or administered; - Tasks not performed or administered must be reported to the Director of Wellness and/or Administrator and followed up on to meet the resident's needs; and - Director of Wellness, Administrator or designee are responsible for ensuring completeness of documentation." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in	01500		

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01500	Continued From page 15 the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies,	01500		

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01500	Continued From page 16 assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of three employees (licensed practical nurse (LPN)-B). In addition, the licensee failed to include the required training topics for the annual training. 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: LPN-B was hired on October 1, 2019, and provided direct care services to residents. LPN-B's employee record lacked documentation of required annual training for the following: - reporting maltreatment and vulnerable adults; - assisted living bill of rights; - review of provider's policies and procedures; and - principles of person-centered planning/service delivery. On January 18, 2023, at 11:26 a.m., LPN-B stated she did have some of the required annual training but was aware some was missing.	01500		

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01500	Continued From page 17 On January 18, 2023, at 11:26 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated their office sent over all of LPN-B's annual trainings and likely wasn't any further documentation. The licensee's Annual Required Staff Training MN policy dated February 2022, indicated, "The following training elements MUST be included every 12 months to all staff who performs direct care services: - Training on reporting of maltreatment of vulnerable adults under section 626.557; - Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person."	01500		

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01500	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (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 interview and record review, the licensee failed to ensure the required two (2) hours of annual dementia care training for each 12 months of employment was completed for direct-care employees in the required time frame for one of two employees (licensed practical nurse (LPN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01540		

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01540	Continued From page 19 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: LPN-B was hired on October 1, 2019, and provided direct care services to residents. LPN-B's employee record lacked documentation of the required two (2) hours of annual dementia care training. On January 18, 2023, at 11:26 a.m., LPN-B stated she did have some of the required annual training but was aware some was missing. On January 18, 2023, at 11:26 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated their office sent over all of LPN-B's annual trainings and likely wasn't any further documentation. LALD/RN-A stated she was aware of the required two (2) hours of dementia training annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=I	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident	01620		

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reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.
(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment with a removal of security in the living environment for one of one resident (R2) who required a secured unit. Further, the licensee failed to ensure the RN conducted an assessment not to exceed 90 calendar days from the last date of assessment for one of one resident (R3), and conducted a change in condition (CIC) assessment for one of one resident (R1).

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,

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01620	Continued From page 21 or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: SECURITY REMOVAL R2 was admitted on September 27, 2021, and resided on the second floor of the licensee's facility. R2's Service Plan dated September 2, 2022, read, "Staff will check on resident daily to ensure safety and wellness." R2's MN Health Assessment and Uniform Results dated September 2, 2022, read, "Resident service needs - Receives memory care services." R2's Vulnerabilities Assessment/Individual Abuse Prevention Plan Results dated September 2, 2022, read, "Approach/Intervention Plan for Wander/Elopement Risk - Secure Environment." On January 17, 2023, at 10:00 a.m., during the entrance conference, assisted living director (ALD)-C indicated the licensee's facility included three secured units requiring the use of a key fob to exit. The two secured memory care units were on floors one and three - no residents on these units were provided with a key fob to leave the unit when they desired. The secured assisted living unit was on floor two - some, but not all, residents on this unit were provided with a key fob to leave the unit when they desired. On January 17, 2023, at approximately 11:30	01620		

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01620	Continued From page 22 a.m., during a tour of floor two, ALD-C stated some residents on the second floor did not have a key fob to exit the unit, as they were not considered safe by the RN's assessment or the resident's family did not want the resident to have a key fob for their safety. On January 19, 2023, at 3:06 p.m., environmental engineer (EE)-I indicated via email the 2nd floor unit of the facility had been unlocked. EE-I indicated he was doing his inspection and witnessed a resident travel down the elevator from the second floor to the first floor unattended. The resident was heading out the front entrance door of the lobby before staff stopped her and told him she had dementia. EE-I was told by the staff member the resident would be moving to a different floor once the family approved the move. On January 19, 2023, at 4:48 p.m., the surveyor interviewed licensed assisted living director (LALD)/RN-A via phone. LALD/RN-A stated the resident who attempted to elope was R2. LALD/RN-A stated she assessed R2 yesterday and did not consider R2 an elopement risk. On January 19, 2023, at 5:08 p.m., the surveyor interviewed LALD/RN-A via phone. LALD/RN-A stated the licensee had two staff members on R2's floor with one of the staff members monitoring R2 on a 1:1 (one staff member watching R2 at all times). LALD/RN-A stated she was not sure why R2 did not previously have a fob to exit the 2nd floor and R2's family had never requested a fob for her. LALD/RN-A stated she was not sure if there were other residents on the 2nd floor who were not allowed to have fobs and no other residents on the 2nd floor were assessed for elopement. LALD/RN-A stated R2 was the most cognitively deficient of all residents	01620		

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on the 2nd floor. LALD/RN-A stated she did a face-to-face assessment with R2 on January 12, 2023, and reached out to the family who requested no changes to R2's services until they were able to meet with the nurse. LALD/RN-A stated at the time of her assessment on January 12, 2023, R2 was not an elopement risk. LALD/RN-A indicated she did not provide a copy of the assessment to the surveyor as she had not entered it into the system. LALD/RN-A stated she did not review any previous nursing assessments for R2 before unlocking the 2nd floor doors. LALD/RN-A stated she was actively trying to get another staff member to work the overnight shift to continue with the 1:1 for R2. LALD/RN-A stated she could not guarantee R2 would stay on the unit independently without a 1:1. LALD/RN-A stated she was actively trying to get a hold of ALD-C who knew how to relock the 2nd floor doors. LALD/RN-A stated ALD-C worked with the door company who came out to show her how to unlock the 2nd floor door and which key needed to be used. LALD/RN-A was not sure which key need to be used.

On January 19, 2023, at 5:31 p.m., LALD/RN-A stated she was leaving immediately to return to the facility tonight to address the issue.

ASSESSMENT GREATER THAN 90 DAYS
R3 was admitted on July 8, 2021.

R3's MN Health Assessment and Uniform Results dated January 12, 2023, was identified by LALD/RN-A as R3's most recent nursing assessment.

R3's previous nursing assessment was completed on August 22, 2022, placing 143 days between the RN's completion of R3's

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 24 assessments. On January 18, 2023, at approximately 10:00 a.m., LALD/RN-A stated R3's assessment was not completed as required. LALD/RN-A stated the licensee had a RN quit and during the transition period, some of the required assessments were not completed, but after another RN was brought in to help, all assessments have been completed for residents. MONITORING CHANGE OF CONDITION R1's diagnoses were cognitive disorder, delirium, hallucinations and spinal stenosis. R1's service plan dated December 14, 2022, indicated R1 did not require transfer assist. R1's uniform 90-day nursing assessment completed on December 13, 2022, by LALD/RN-A, indicated R1 required assistance of one (1) person transferring without a mechanical lift. On January 18, 2023, at 7:42 a.m., unlicensed personnel (ULP)-G and ULP-K were observed providing cares for R1 in R1's room. ULP-G and ULP-K were getting R1 ready to be transferred out of bed. ULP-G and ULP-K were looking for a transfer belt to assist with the transfer, ULP-K stated a transfer belt was not required for R1's transfer but was nice to have. ULP-G stated she thought a transfer belt was required but could not find it, both ULPs proceeded to transfer R1 from her bed into her wheelchair (w/c). R1 provided minimal assistance with the transfer, ULP-G and ULP-K were lifting her up under her armpits in attempt to pivot transfer, R1 was observed being unable to bear weight. ULP-G and ULP-K were able to get R1 into her w/c and rolled her into the	01620		

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01620	Continued From page 25 bathroom where they both assisted R1 with dressing and transfer onto and off the toilet. ULP-G and ULP-K both stated R1 was at one point a 1-person transfer, but was getting weaker and weaker every day and now required a full 2-person transfer. On January 18, 2023, at 12:47 p.m., LALD/RN-A stated R1 was a 1-person transfer. LALD/RN-A stated they do not provide 2-person transfers and their Uniform Disclosure of Assisted Living Services and Amenities (UDULSA) document addresses it as a service they did not provide. Surveyor explained a transfer of R1 was observed on January 18, 2023, at 7:42 a.m. and it was a full 2-person assist. LALD/RN-A stated it sounded like a change in condition for R1. LALD/RN-A stated it was hard to know of a CIC if the ULPs weren't notifying the nurse of changes. The licensee's 2.01MN Assessments, Reviews & Monitoring policy dated July 2021, indicated ongoing reassessments must be conducted as needed based on changes in the needs of the resident and would not exceed 90 calendar days from the last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed after the time of exit on January 19, 2023, by evaluation supervisor on January 23, 2023, however noncompliance remains at a scope and level of I.	01620		
01640 SS=I	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 26 (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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement a service plan based on a current registered nurse's (RN) assessment for one of one resident (R2) who required a secured unit and licensee failed to ensure the current service plan included a signature or other authentication by resident or resident's representative to document agreement on the services to be provided for three of three residents (R1, R2, R3). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to	01640		

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01640	Continued From page 27	01640		

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:

SECURITY REMOVAL
R2 was admitted on September 27, 2021, and resided on the second floor of the licensee's facility.

R2's Service Plan dated September 2, 2022, read, "Staff will check on resident daily to ensure safety and wellness." R2's service plan lacked services related to providing a secured environment as indicated by R2's RN assessments.

R2's MN Health Assessment and Uniform Results dated September 2, 2022, read, "Resident service needs - Receives memory care services."

R2's Vulnerabilities Assessment/Individual Abuse Prevention Plan Results dated September 2, 2022, read, "Approach/Intervention Plan for Wander/Elopement Risk - Secure Environment."

On January 17, 2023, at 10:00 a.m., during the entrance conference, assisted living director (ALD)-C indicated the licensee's facility included three secured units requiring the use of a key fob to exit. The two secured memory care units were on floors one and three - no residents on these units were provided with a key fob to leave the unit when they desired. The secured assisted living unit was on floor two - some, but not all, residents on this unit were provided with a key fob to leave the unit when they desired.

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01640	Continued From page 28 On January 17, 2023, at approximately 11:30 a.m., during a tour of floor two, ALD-C stated some residents on the second floor did not have a key fob to exit the unit, as they were not considered safe by the RN's assessment or the resident's family did not want the resident to have a key fob for their safety. On January 19, 2023, at 3:06 p.m., environmental engineer (EE)-I indicated via email the 2nd floor unit of the facility had been unlocked. EE-I indicated he was doing his inspection and witnessed a resident travel down the elevator from the second floor to the first floor unattended. The resident was heading out the front entrance door of the lobby before staff stopped her and told him she had dementia. EE-I was told by the staff member the resident would be moving to a different floor once the family approved the move. On January 19, 2023, at 4:48 p.m., the surveyor interviewed licensed assisted living director (LALD)/RN-A via phone. LALD/RN-A stated the resident who attempted to elope was R2. LALD/RN-A stated she assessed R2 yesterday and did not consider R2 an elopement risk. On January 19, 2023, at 5:08 p.m., the surveyor interviewed LALD/RN-A via phone. LALD/RN-A stated the licensee had two staff members on R2's floor with one of the staff members monitoring R2 on a 1:1 (one staff member watching R2 at all times). LALD/RN-A stated she was not sure why R2 did not previously have a fob to exit the 2nd floor and R2's family had never requested a fob for her. LALD/RN-A stated she was not sure if there were other residents on the 2nd floor who were not allowed to have fobs and no other residents on the 2nd floor were	01640		

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assessed for elopement. LALD/RN-A stated R2 was the most cognitively deficient of all residents on the 2nd floor. LALD/RN-A stated she did a face-to-face assessment with R2 on January 12, 2023, and reached out to the family who requested no changes to R2's services until they were able to meet with the nurse. LALD/RN-A stated at the time of her assessment on January 12, 2023, R2 was not an elopement risk. LALD/RN-A indicated she did not provide a copy of the assessment to the surveyor as she had not entered it into the system. LALD/RN-A stated she did not review any previous nursing assessments for R2 before unlocking the 2nd floor doors. LALD/RN-A stated she did not know why the service plan was not updated with R2's needs as she did not know what past services R2 receieved. LALD/RN-A stated she was actively trying to get another staff member to work the overnight shift to continue with the 1:1 for R2. LALD/RN-A stated she could not guarantee R2 would stay on the unit independently without a 1:1. LALD/RN-A stated she was actively trying to get a hold of ALD-C who knew how to relock the 2nd floor doors. LALD/RN-A stated ALD-C worked with the door company who came out to show her how to unlock the 2nd floor door and which key needed to be used. LALD/RN-A was not sure which key need to be used.

On January 19, 2023, at 5:31 p.m., LALD/RN-A stated she was leaving immediately to return to the facility tonight to address the issue.

AUTHENTICATION
R1 was admitted on December 27, 2019.

R1's unsigned Service Plan dated December 14, 2022, lacked authentication by the licensee and resident or the resident's designated

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01640	Continued From page 30 representative. R2 was admitted on September 27, 2021. R2's unsigned Service Plan dated September 2, 2022, lacked authentication by the licensee and resident or the resident's designated representative. R3 was admitted on July 8, 2021. R3's unsigned Service Plan dated January 12, 2023, lacked authentication by the licensee and resident or the resident's designated representative. On January 18, 2023, at 12:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee's expectation is all service agreements are authenticated by the licensee and the resident or the resident's designated representative. LALD/RN-A indicated they had completed the service agreement but were unsure why they did not obtain the resident's authentication. The licensee's 2.08MN Service Plan policy dated July 2021, read, "2. The service plan and any revisions shall 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, 3. Services plans shall be revised, if needed, based on resident reassessments and monitoring," and "6. [The licensee] will implement and provide all services indicated in the service plan." No further information provided.	01640		

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01640	Continued From page 31 TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed after the time of exit on January 19, 2023, by evaluation supervisor on January 23, 2023, however noncompliance remains at a scope and level of I.	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650		

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01650	Continued From page 32 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included all required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 was admitted on December 27, 2019. R1's Service Plan dated December 14, 2022, lacked a contingency plan with required content. R2 was admitted on September 27, 2021. R2's Service Plan dated September 2, 2022, lacked a contingency plan with required content. R3 was admitted on July 8, 2021. R3's Service Plan dated January 12, 2023, lacked a contingency plan with required content. On January 18, 2023, at approximately 12:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated R1, R2, and R3's service plans lacked the required contingency plan content to include: (i) the action to be taken if the scheduled service	01650		

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01650	Continued From page 33 cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. The licensee's 2.08MN Service Plan policy dated July 21, 2021, indicated the contingency plan required content would be included. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet	01760		

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01760	Continued From page 34 the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document administered medications per provider orders for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's service plan dated December 14, 2022, indicated R1 received medication management services. R1's medication administration records (MAR) for November and December 2022, and January 2023, lacked documentation of medication administration for the following medications: - Australian Dream Cream: apply topically to painful areas (ankle and heel) twice a day for pain (missed 21 doses in November 2022, five doses in December 2022, and three doses in January 2023); - AZO bladder Go-Less: take one capsule by mouth twice a day (missed 21 doses in November 2022, five doses in December 2022, and three doses in January 2023); - Biofreeze 4% Gel: apply to the affected area	01760		

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twice a day (missed 22 doses in November 2022, five doses in December 2022, and three doses in January 2023);
- Blink Gel Tears: instill 1 drop in both eyes every morning (missed one dose in November 2022);
- cephalexin 500 milligrams (mg) capsule: take one capsule by mouth twice a day for seven days for urinary tract infection (missed five doses in November 2022);
- docusate sodium 100 mg capsule: take one capsule by mouth twice a day for constipation (missed 21 doses in November 2022, five doses in December 2022, and three doses in January 2023);
- donepezil 10 mg tablet: take 1/2 (half) a tablet by mouth twice a day for visual hallucinations (missed 21 doses in November 2022, five doses in December 2022, and three doses in January 2023);
- escitalopram 10 mg tablet: take one tablet by mouth daily (missed one dose in November 2022);
- latanoprost 0.0005% solution: instill 1 drop in the right eye every night at bedtime (missed 21 doses in November 2022, five doses in December 2022, and three doses in January 2023);
- loratadine 10 mg tablet: take one tablet by mouth daily (missed one dose in November 2022);
- melatonin 3 mg tablet: take one tablet by mouth every night at bedtime (missed 20 doses in November 2022, five doses in December 2022, and three doses in January 2023,
- mucus relief 600 mg extended release (ER) tablet: take one tablet by mouth twice a day (missed 21 doses in November 2022, five doses in December 2022, and three doses in January 2023);
- Ocuvite tablet: take one tablet by mouth twice a

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01760	Continued From page 36 day for macular degeneration (missed 21 doses in November 2022, five doses in December 2022, and three doses in January 2023); - Oysco 500/D tablet: take one tablet by mouth daily for supplement (missed one dose in November 2022); - PEG3350 (polyethylene glycol) powder: dissolve 1/2 capful in eight ounces (oz) of water and drink daily (missed one dose in November 2022); - triamcinolone 0.1% cream: apply to affected areas topically twice a day (missed nine doses in November 2022); and - vitamin D3 25 micrograms (mcg) tablet: take one tablet by mouth daily for vitamin days deficiency (missed one dose in November 2022). On January 18, 2023, at 12:25 p.m., licensed assisted living director (LALD/RN)-A stated the empty spaces on the MAR should have documentation in them and never left blank. LALD/RN-A stated if the medication had been refused, it should have had a circle around the employee's initials who attempted to administer the medication and documented in the exception section of the MAR with an explanation. The licensee's Medication & Treatment Record - Documentation & Refusal policy dated July 2021, indicated, "If medication and or treatment/therapy assistance and/or administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided." No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01940	Continued From page 37	01940		
01940 SS=F	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 be current and updated when there are any changes. 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	01940		

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	28353	A. BUILDING: _____ B. WING _____	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCORE AT MAHTOMEDI	720 MAHTOMEDI AVENUE MAHTOMEDI, MN 55115

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01940	Continued From page 38	01940		

each resident and documented those instructions in the resident's record for two of three residents (R1, R3) who had ordered treatments.

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

The findings include:

R1
R1's treatment administration record (TAR) for November and December 2022, and January 2023, indicated R1 received assistance with T.E.D. hose/tubing (compression stockings) two times per day.

R1's record lacked specific instructions related to the application of the compression stockings and when to notify a nurse when problems arose with R1's compression stocking application.

R3
R3's Service Plan with activation date of January 12, 2023, indicated R3 received assistance with T.E.D. hose/tubigrips two times per day.

R1's record lacked specific instructions related to the application of the tubigrips and when to notify a nurse when problems arose with R3's tubigrip application.

On January 18, 2023, at approximately 10:00 a.m., licensed assisted living director/RN (LALD/RN)-A stated the licensee did not include

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01940	Continued From page 39 specific instructions for any resident's treatment management plans. LALD/RN-A indicated the licensee had trained staff to contact the RN if any questions arose but did not include specific written instructions for each resident in their record. The licensee's 2.29MN Treatment & Therapy Management Plan policy dated July 2021, indicated resident's treatment management plans would include specific written instructions for each resident and when to contact a nurse if problems arose. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=F	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 documentation of administration or the reason why a treatment was	01960		

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01960	Continued From page 40 not administered for two of three residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's treatment administration record (TAR) for November and December 2022, and January 2023, indicated R1 received assistance with T.E.D. hose/tubing (compression stockings) two times per day. R1's TAR for November and December 2022, and January 2023, lacked documentation of administration of T.E.D.s on: - January 12 and 13, 2023; - December 1-5, 2022; and - November 1-7, 9-12, 14-20, and 22-29, 2022. R3 R3's Service Plan with activation date of January 12, 2323, indicated R3 received assistance with T.E.D. hose/tubigrips two times per day. R3's MAR (medication administration record) dated January 2023, lacked documentation of administration on January 2, January 11, and January 14, 2023, at 8:00 a.m., related to R3's tubigrips. R1 and R3's treatment management record	01960		

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01960	Continued From page 41 lacked documentation of the reason why the treatment was not documented as completed by the unlicensed personnel and lacked documentation of the follow up to meet the resident's needs when the treatment was not administered. On January 18, 2023, at approximately 10:00 a.m., licensed assisted living director/RN (LALD/RN)-A stated the licensee was not sure why the treatment was not documented as completed and the expectation is documentation for any treatment not administered would be maintained in the resident record. On January 18, 2023, at 12:25 p.m., licensed assisted living director (LALD/RN)-A stated the empty spaces on the TAR should have documentation in them and never left blank. LALD/RN-A stated if the medication or treatment had been refused, it should have had a circle around the employee's initials who attempted to administer the medication and documented the reason in the exception section of the MAR with an explanation. The licensee's 2.60MN Mediation & Treatment Record - Documentation & Refusal policy dated July 2021, indicated resident's treatments would be documented when administered and documentation for all refusals or reasons a treatment was not administered would be included in the resident record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

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02070	Continued From page 42	02070		
02070 SS=I	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: Based on observation, interview, and record review, the licensee failed to ensure an awake person was physically present in a secured care unit, 24 hours a day, seven days a week who was responsible for responding to requests of residents for assistance in a secured area. This had the potential to affect all residents in the secured dementia care unit. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 17, 2023, at 10:00 a.m., during the entrance conference, administrator (A)-C indicated the licensee's facility included three secured units requiring the use of a key fob to exit. The two secured memory care units were	02070		

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02070	Continued From page 43	02070		

on floors one and three - no residents on these units were provided with a key fob to leave the unit when they desired. The secured assisted living unit was on floor two - some, but not all, residents on this unit were provided with a key fob to leave the unit when they desired. A-C stated each unit is staffed with one unlicensed personnel (ULP) on the night shift from 11:00 p.m. until 7:30 a.m. Additionally, A-C stated the ULP who worked on the second floor on the night shift was the only ULP who was trained to pass medications in the facility. A-C stated the second floor ULP would leave the second floor unattended to pass medications if needed on the first and third floor.

On January 17, 2023, at approximately 11:30 a.m., during a tour of floor two, A-C stated some residents on the second floor did not have a key fob to exit the unit, as they were not considered safe by the registered nurse's (RN) assessment or the resident's family did not want the resident to have a key fob for their safety.

R3 was admitted on July 8, 2021.

R3's incident report dated November 25, 2022, indicated R3 sustained a fall at 3:45 a.m., during the night shift working hours. Additionally, the report read, "11/25/2022 - 4:00AM Measured Vital Signs, Staff Assisted." The incident report lacked identification of the method staff utilized to assist R3 from the floor.

On January 18, 2023, at 6:47 a.m., ULP-G stated the ULPs working on the night shift on second floor, would leave the unit to assist on the other two units if needed. This would leave second floor without a staff member during those times.

On January 18, 2023, at 6:52 a.m. ULP-F stated

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02070	Continued From page 44 the ULPs working on the night shift on second floor, would leave the unit to assist on the other two units if needed which would leave second floor without a staff member during those times. On January 18, 2023, at approximately 8:00 a.m., ULP-E stated when residents fall, staff would use a two person lift to get residents off the floor when they fell. ULP-E stated a two-person lift should have been used when R3 sustained a fall but was not sure if a two-person lift was actually used or if the fire department was called. Additionally, ULP-E stated the second-floor staff would leave to assist first and third floor during night shifts if needed. On January 18, 2023, at approximately 9:15 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee does not use a two person Hoyer mechanical lift unless the resident is on hospice and resides on floor one or floor three. LALD/RN-A indicated licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated December 28, 2022, indicated, "Mechanical lift: assist of 2 transfer - When on hospice. Must reside in Memory Care - not accepted in AL." LALD/RN-A stated staff should be calling the local fire department, "who really hate us," when a fall occurs to assist the resident off the floor. Additionally, LALD/RN-A indicated the staff member on second floor does not leave the unit often on night shift, but if a resident on the other floors required an as needed medication, they (the second-floor staff member) are the only medication administration trained staff in the entire building. LALD/RN-A acknowledged that based on the fact there are some residents without key fob and are not able to leave second floor on their own accord, second floor would be	02070		

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02070	Continued From page 45 considered a locked memory care unit and should be staffed at all times. The licensee's, Community Staffing Pattern MN policy dated June 2020, indicated the licensee would staff, "based on the needs of the residents," and "ensure one of more staff are available 24 hours per day, seven days per week, who are responding to the requests of the residents for assistance with health or safety needs." No further information provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed after the time of exit on January 19, 2023, by evaluation supervisor on January 23, 2023, however noncompliance remains at a scope and level of I.	02070		
02110 SS=F	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	02110		

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02110	Continued From page 46 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 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 interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	02110		

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02110	Continued From page 47 R1 was admitted on December 27, 2019. R2 was admitted on September 27, 2021. R3 was admitted on July 8, 2021. R4 was admitted on July 31, 2022. R1, R2, R3, and R4's records lacked documentation they or their designated representatives received the required policies and procedures (P/P) to be provided. On January 18, 2023, at 1:00 p.m., administrator (A)-C indicated the licensee was aware the identified policies and procedures were required to be provided to the residents at the time of move in. A-C stated although the licensee had developed the required P/P, but the licensee failed to provide the P/P to any resident who resided in the facility. No further information 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	02170		

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02170	Continued From page 48 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 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 ensure an individualized activity plan contained all required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	02170		

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02170	Continued From page 49 or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on December 27, 2019. R1's record lacked an activities evaluation to address the residents' past interests, current abilities and skills, emotional and social needs and patterns, physical limitations, and identifications of activities for behavioral interventions. R2 R2 was admitted on September 27, 2021. R2's record lacked an activities evaluation to address the residents' past interests, current abilities and skills, emotional and social needs and patterns, physical limitations, and identifications of activities for behavioral interventions. R3 R3 was admitted on July 8, 2021. R3's record lacked an activities evaluation to address the residents' past interests, current abilities and skills, emotional and social needs and patterns, physical limitations, and identifications of activities for behavioral interventions. R4 R4 was admitted on July 31, 2022. R4's record lacked an activities evaluation to address the residents' past interests, current	02170		

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02170	Continued From page 50 abilities and skills, emotional and social needs and patterns, physical limitations, and identifications of activities for behavioral interventions. On January 18, 2023, at approximately 1:00 p.m., administrator (A)-C stated R1, R2, R3, and R4's activities evaluation had not been completed. A-C indicated, although the licensee had developed an activities evaluation form with the required content, the licensee failed to complete the activities evaluation for any resident residing in the facility. The licensee's 3.01MN Activity Evaluation and Plan policy dated December 2022, indicated an activities assessment would be completed for each resident, and identification of the required content for the evaluation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

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

Type: Full
Date: *01/18/23*
Time: 10:30:00
Report: 1005231009

Food and Beverage Establishment Inspection Report

Location:
The Encore At Mahtomedi
720 Mahtomedi Avenue
Mahtomedi, MN55115
Washington County, 82

Establishment Info:
ID #: 0038816
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6515288442
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.

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

THE CAN OPENER BLADE HAD DRIED ON FOOD DEBRIS PRESENT. CLEANED ON SITE.

Comply By: 01/18/23

2-100 Supervision

2-102.12AMN

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

THE MANAGER'S CFPM CERTIFICATE JUST EXPIRED. MANAGER HAD CEU CERTIFICATE ON SITE, AND STATED SHE HAS ALREADY SUBMITTED IT FOR RENEWAL.

Comply By: 02/18/23

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

THE DISH TABLE ON EITHER SIDE OF THE DISH MACHINE IS NOT SEALED TO THE WALL.

Comply By: 02/01/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200+PPM at Degrees Fahrenheit
Location: 3-COMP DISPENSER
Violation Issued: No

Utensil Surface Temp.: = at 164 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/LIQUID EGG
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/BUTTER
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/CHICKEN
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/BEEF
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Thawing/CHICKEN
Temperature: 32 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: 3RD FLOOR KITCHENETTE COOLER
Violation Issued: No

Process/Item: Cold Hold/AMBIENT
Temperature: 40 Degrees Fahrenheit - Location: 2ND FLOOR KITCHENETTE COOLER
Violation Issued: No

Process/Item: Cold Hold/AMBIENT
Temperature: 38 Degrees Fahrenheit - Location: 1ST FLOOR KITCHENETTE COOLER
Violation Issued: No

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

INSPECTION COMPLETED WITH KITCHEN MANAGER AND REVIEWED WITH HRD NURSE EVALUATOR JOEY KEEN.

DISCUSSED ORDERS ON REPORT, EMPLOYEE ILLNESS, DATE-MARKING, COOKING TEMPERATURES, BARE HAND CONTACT, AND THERMOMETER CALIBRATION.

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 1005231009 of 01/18/23.

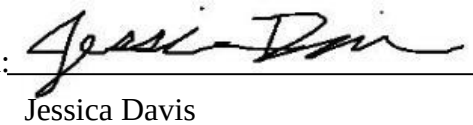
Certified Food Protection Manager: HOLLY M. THOMPSON

Certification Number: FM103229 Expires: 01/13/23

Inspection report reviewed with person in charge and emailed.

Signed: _____

HOLLY THOMPSON
KITCHEN MANAGER

Signed: 

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Public Health Sanitarian III
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