DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 27, 2023

Licensee
Cottagewood Senior Communities
4310 55th Street Northwest
Rochester, MN 55901

RE: Project Number(s) SL20391015

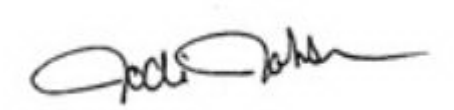
Dear Licensee:

On April 18, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 26, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

HHH

Electronically Delivered

March 6, 2023

Licensee
Cottagewood Senior Community
4310 55th Street Northwest
Rochester, MN 55901

RE: Project Number(s) SL20391015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 26, 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 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,500.00. 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:

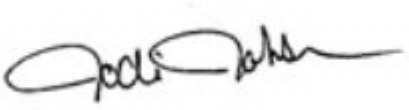
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 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
	20391	A. BUILDING: _____ B. WING _____	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGEWOOD SENIOR COMM	4310 55TH STREET NW ROCHESTER, MN 55901

(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: SL20391015-0 On January 23-26, 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 138 active residents; 138 receiving services under the Assisted Living with Dementia Care license. 2310: An immediate correction order was issued on January 25, 2023. The immediacy was removed; however, non-compliance remains at a level 3, isolated scope (G).	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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250		

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0 250	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under	0 250		

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0 250	Continued From page 2 section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 23, 2023, at 10:00 a.m., licensed assisted living	0 250		

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0 250	Continued From page 3 director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which	0 250		

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0 250	Continued From page 4 may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250		

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0 250	Continued From page 5 - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by the authorized agent on May 19, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of April 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - infection control practices; and - medication and treatment management; As a result of this survey, the following orders were issued 0510, 0620, 0640, 1620, 1730, 1780,	0 250		

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0 250	Continued From page 6 1830, 1880, 1890, 1940, 1960, 1970, 2310 and 3000 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 510 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 and interview, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control with management of wound care and hand hygiene with registered nurse (RN)-E, and proper hand hygiene with one of two unlicensed personnel (ULP-J). Additionally, the licensee failed to maintain infection control with a medication mini-refrigerator. This had the	0 510		

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0 510	Continued From page 7 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 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: WOUND CARE AND HAND HYGIENE During observation on January 24, 2023, at 9:55 a.m. R6 was noted to be in his room sitting in his broda chair (a chair with a high back and lateral supports). RN-E washed her hands and put on gloves prior to starting R6's wound care. RN-E removed the dressing from the bottom of R6's left heel and discarded it. The dressing had notable drainage on it. With the same gloves, she used a small mirror to view underneath R6's heel, used wound cleanser applied to gauze and cleansed the heel wound. With the same gloves, she applied flagyl (a topical antibiotic) and iodine to a clean dressing and placed the dressing to the wound. Using the same gloves, RN-E moved on to the dressing on R6's left ankle/left side of leg, removed the dressing which also contained drainage, discarded the dirty dressing, cleansed the wound with wound spray cleanser, applied a clean mepilex dressing (a dressing with adhesive bordered edges) and put on R6's sock and protective foam boot. RN-E then moved on to R6's right ankle, with the same gloves and pulled back the edges of the dressing to view the wound on the left ankle. RN-E re-secured the dressing and put his sock back on. RN-E then took off her	0 510		

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0 510	Continued From page 8 gloves discarded them and washed her hands. During observation on January 24, 2023, at 1:20 p.m. R6 was observed in his bed lying on his right side. RN-E had gathered supplies to complete wound care and dressing change for R6's right gluteal cleft (right buttock) wound. RN-E donned (put on) clean gloves, removed the previous dressing, noted two open areas on R6's right gluteal cleft with foul odor/drainage. RN-E cleansed the wound area with saline wash and gauze and removed her gloves. Without washing her hands or reapplying gloves, RN-E opened the package containing a clean dressing, applied and secured the dressing to the right gluteal wound area, assisted the ULP with the placement of R6's incontinence brief, and picked up and discarded the dirty dressings and packaging. RN-E then went to R6's bathroom and washed her hands. On January 24, 2023, at 3:45 p.m. RN-B stated she expected RN-E "to always work from clean to dirty areas, change gloves and wash/disinfect hands with each step of wound care." Additionally, RN-B stated she expected RN-E "to remove dirty gloves, and apply a clean dressing with clean gloves, not ungloved hands, then remove gloves and assist with other needs after cleansing her hands." During observation on January 24, 2023, at 9:40 a.m. ULP-I and ULP-J were observed to assist R5 with placement of an EZ stand (mechanical sit to stand lift) sling placement, placed R5 on the toilet and provided stand by safety. ULP-J donned gloves to cleanse R5's bottom after toileting with toilet paper and a wipe. Using the same gloves, ULP-J moved R5's wheelchair for transfer with the EZ stand, removed the EZ stand sling, placed	0 510		

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0 510	Continued From page 9 R5's wheelchair foot pedals on her chair and grabbed the EZ stand handles to move it to it's designated location. ULP then removed gloves and washed hands. On January 24, 2023, at 4:00 p.m. RN-B stated her expectation was for "ULP to remove gloves after toileting and peri-care and to wash hands before touching other surfaces." MEDICATION MINI-REFRIGERATOR On January 24, 2023, at 8:30 a.m. ULP-I was observed to set up medications for R in the medication room. The surveyor observed a mini-refrigerator sitting on the floor in the medication room. When ULP-I opened the mini-refrigerator, the surveyor observed the bottom of the mini-refrigerator covered in cat hair. ULP-I confirmed the cottage had a resident cat. The mini-refrigerator also had spilled medication inside the mini-refrigerator door. ULP-I stated she was the person who mainly managed the contents of the mini-refrigerator and the temperature log, and had not noticed the cat hair. Additionally, the mini-refrigerator had an open freezer compartment with a significant amount of frost build up. ULP-I stated she would make arrangements to store the medications elsewhere and contact maintenance to defrost and clean the mini-refrigerator. The contents of the mini-refrigerator included: Risperdal-two vials (antipsychotic) Novolog 70/30-8 pens (insulin) Novolin 100 mg (milligrams)/ml (milliliters)-six pens (insulin) lantus Solostar-two pens (insulin) lorazepam- six bottles (30 ml) (antianxiety) suppositories- two boxes plus two bags of ten	0 510		

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0 510	Continued From page 10 suppositories latanoprost eye drops-one bottle (treats eye pressure) On January 24, 2023, at 3:25 p.m. licensed assisted living director (LALD)-A stated "nursing should be monitoring contents and ensuring good infection control with the medication cart and mini-refrigerators across the campus." The licensee's policy and procedure for using gloves dated July 23, 2021, read, gloves are to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressings. Gloves will be removed carefully and disposed of in a proper container. The procedure read as follows: 1. Wash Hands 2. Apply gloves to both hands 3. Complete task. If gloves become torn or heavily soiled and additional tasks must be performed for the client, then change the gloves (washing hands before putting on new gloves before starting the next task. 4. Place any contaminated materials in proper receptacle - such as biohazardous waste for wound care dressings. 5. Remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff of remaining glove and pull off, turning inside out with first glove inside the second glove. 6. Dispose of used gloves in proper receptacle - biohazardous if they have contaminated material on them. 7. Rewash hands.	0 510		

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0 510	Continued From page 11 The licensee's Hand Hygiene policy dated July 23, 2021, indicated the following: 1. When Hands Should be Washed. Hand washing shall be performed between client cares and whenever direct physical contact with a client takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: a. Before and after direct contact with a client b. If moving from a contaminated-body site to a clean-body site during client care c. After contact with environmental surfaces or equipment in the immediate vicinity of the client d. After removing gloves or gowns e. Before eating and after using a restroom The licensee's Disinfecting reusable equipment and environmental surfaces policy dated July 25, 2021, read as follows: Environmental Services a. Environmental surfaces must be disinfected after use. b. Put on gloves. c. Clean any obvious soiled material with paper towels and soapy water. d. Then spray with premixed sterilizing solution or 1:10 bleach solution or sterilizing product approved by the RN. e. Allow the equipment to air dry on a clean paper towel. a. Follow manufacturers time that the surface must remain "wet" with the solution applied. i. The RN may write the amount of time required on the original container for ease of staff to know. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) for a significant medication error for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 service plan dated August 24, 2022, indicated he received services to include medication administration. The licensee's Initial Medication Incident Report dated January 5, 2023, indicated R2 had received hydromorphone HCL (a narcotic pain reliever) in a 10 mg/ml (milligram/milliliter) solution. With the dose to be 0.2 ml at 8:00 p.m. the incident form	0 620		

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0 620	Continued From page 13 indicated the incident in detail: MA [medication assistant] gave the resident 2 [two] ml instead of giving 0.2 ml. (the dose given is 10 times the dose ordered). Observations made and instructions per HSD (health services director): Continue to monitor for adverse reactions, notified hospice nurse, notified NP [nurse practitioner], regular checks, vital signs. Immediate actions taken for resident: Followed physician's orders, instructions included in resident service notes, observations made per HSD's instruction. Final Resident Outcome: No adverse outcome Narrative of Investigation: On investigation it was noted that [R2] was given 2 ml instead of being given 0.2 ml. This caused him to become drowsy. MA immediately notified nursing of her error. Nursing called hospice who delivered a dose of Narcan. No adverse effects occurred further. Possible Contributing Factors: failure to check meds against MARS (medication administration record), failure to follow policy and procedure, frequent distractions, misread medication label. Corrective action taken: discussed 7 [seven] medication rights, discussed 3 [three] checks. The licensee failed to report the significant medication error to MAARC. On January 26, 2023, at 4:30 p.m. RN-B and LALD-A stated based off what was written, they did not feel it met the criteria for reporting to MAARC. The licensee's Vulnerable Adult Maltreatment policy dated July 20, 2021, indicated a. Any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately to their supervisor, a nurse, or the	0 620		

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0 620	Continued From page 14 Licensed Assisted Living Director (LALD) and that person will complete an incident report. a. If the incident appears to be suspected abuse, neglect or financial exploitation, the LALD or designee will immediately make a report to MAARC ("Immediately" means as soon as possible, but no longer than 24 hours from the time the LALD or designee received initial knowledge that the incident occurred). b. If it is unclear based whether maltreatment has occurred, an investigation into the incident will begin immediately. c. If within the 24 hours following the initial incident report, it is still unclear whether reportable maltreatment has occurred, a report will be made to MAARC. d. If it appears that a crime may have been committed, the LALD or designee will immediately contact the police if the witness has not already done so. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center	0 640		

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0 640	Continued From page 15 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 support protection and safety by failing to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of residents). The findings include: On January 23, 2023, at 1:30 p.m. during the facility tour of cottage number four with licensed assisted living director (LALD)-A, the surveyor noted the main entrance and/or common areas lacked the required posting for 911. On January 26, 2023, at 5:20 p.m. LALD-A entered cottage number eight with the surveyor to look for 911 posting. LALD-A confirmed the sign was only posted in the locked nurse area and stated you will not find them in the common areas in any of the cottages. No further information was provided.	0 640		

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0 640	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (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;	0 730		

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0 730	Continued From page 17 (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 observation, interview, and record review, the licensee failed to ensure documentation of content in the resident's record as required for four of six residents (R5, R6, R3, R4) and lacked the required content of a discharge summary (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R5 R5's Service plan dated November 29, 2022, indicated R5 received services to include medication administration, glasses assistance, skin integrity checks, life enrichment	0 730		

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0 730	Continued From page 18 programming, two person assistance with bathing and dressing, right foot brace, one person assistance grooming, oral care and eating, one person assist with wheelchair mobility and two person assist with toileting, transfers and with any gait belt and walker use. On January 24, 2023, at 9:40 a.m. the surveyor observed unlicensed personnel (ULP)-I and ULP-J assist R5 in the bathroom to transfer from her manual wheelchair with use of the EZ stand (mechanical sit-to-stand lift) to the toilet, provided stand by assistance for toileting, cleansed her bottom after toileting, and used the EZ stand to return R5 to her wheelchair. R5's Service Check off List dated January 2023, lacked consistent documentation of tasks provided for the following: -Grooming -Laundry Linens/towels -Life Enrichment Programming -Mobility-one person assist -Oral hygiene -Privacy-lockable doors -Room Pick up -Skin integrity -Toileting- two assist -Transferring- two person assist -Eating-one person assist -2-5170 safety checks -COVID sanitizing -Daily bed making -Dressing two person assist -Escort -Frequent redirection/reassurance -Glasses assistance -Grooming one person assistance	0 730		

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0 730	Continued From page 19 R6 R6's Service Plan dated October 10, 2022, indicated R6 received services to include medication administration, suprapubic catheter management, bathing, dressing, grooming, behavior redirection/assurance, life enrichment programming, mobility assistance with Broda chair (a high backed specialized chair which provides full body and lateral support), and two person assist with hoyer (mechanical lift) transfers. On January 24, 2023, at 8:55 a.m. ULP-F and hospice massage therapist (HMT)-G were observed to assist R6 with changing an incontinence brief and completed dressing R6's lower body. The hospital bed had upper bed rails on both sides of the hospital bed. ULP-F and HMT-G transferred R6 to the Broda chair with the use of a hoyer lift. R6's Service Check off List dated January, 2023, lacked consistent documentation of tasks provided for the following: -2-5170 Safety checks -Covid sanitizing -Daily bed making -Dressing-one person assistance -Frequent redirection/reassurance -Grooming -Laundry linens/towels -Life enrichment programming -Mobility-one person assistance -Oral hygiene -Privacy-lockable doors -Room pick up -Skin integrity -Therapy/treatment plan-compression stockings, catheter bag maintenance -Transfers two person assistance	0 730		

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0 730	Continued From page 20 -Eating reminders -Bathing -Frequent redirection/reassurance On January 26, 2023, at 4:50 p.m. licensed assisted living director (LALD)-A and registered nurse (RN)-B stated, "The usual practice is for the campus team lead to complete an audit of all resident check off lists, which is to be done a couple times each month. Obviously this is missing." R3 R3's diagnosis included dementia with Lewy bodies, hypertension, and hyperlipidemia (high cholesterol). R3 started receiving services from the licensee on October 17, 2022, to assist with medication management and assistance with ADLs. R3's Monthly Service Check off List dated January 2023, lacked consistent daily documentation of completed tasks on January 12, 14, 19, and 20th, for the following: -Safety checks -Bathing -COVID sanitizing -Daily bed making -Dressing -Escort -Frequent redirection/reassurance -glasses assistance -grooming -laundry -life enrichment programming -mobility -oral hygiene -privacy -room pick-up	0 730		

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0 730	Continued From page 21 -shaving -skin integrity -toileting -transferring -cueing while eating On January 25, 2023, at 9:14 a.m. the surveyor observed two ULP assisting R3 with toileting, grooming, dressing, and transferring to Broda chair. R4 R4's diagnosis included unspecified dementia with behavioral disturbance, dysphagia (difficulty swallowing), and hyperlipidemia. R4 started receiving services from the licensee on September 30, 2022, to assist with medication management services and assistance ADLs. R4's Monthly Service Check off List dated January 2023, lacked consistent daily documentation of completed tasks on January 10, 18, 19 and 20th, for the following: -Safety checks -Bathing -COVID sanitizing -Daily bed making -Dressing -Escort -Frequent redirection/reassurance -glasses assistance -grooming -laundry -life enrichment programming -mobility -oral hygiene -privacy -room pick-up -shaving	0 730		

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0 730	Continued From page 22 -skin integrity -toileting -transferring -eating reminders On January 26, 2023, at 1:40 p.m. RN-B confirmed the above. Discharge Summary R1 R1's diagnosis included Alzheimer's disease, ataxia (poor muscle control), and hemiplegia (paralysis on one side of the body). R1 started receiving services from the licensee on June 28, 2022, to assist with medication management and assistance with activities of daily living (ADLs) and discharged from services on August 31, 2022. R1's record included a medication disposition form but lacked evidence of a completed discharge summary at the time of discharge. On January 23, 2023, at 2:00 p.m. RN-B indicated she was aware the residents are required to have a discharge summary and medication disposition form and confirmed R1's record did not include a discharge summary. The licensee's Resident Records policy dated July 28, 2021, indicated the resident record will contain documentation that services have been provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 730		

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0 780	Continued From page 23	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with statute requirements. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20391	A. BUILDING: _____ B. WING _____	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGEWOOD SENIOR COMM	4310 55TH STREET NW ROCHESTER, MN 55901

(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 24 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On January 24, 2023, between 10:00 a.m. and 1:00 p.m., survey staff toured the facility with the maintenance coordinator (MC)-D. During the facility tour, survey staff observed that smoke alarms were not installed in resident sleeping rooms in cottages 1 and 4. This deficient condition was verified by MC-D accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	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 licensee failed to maintain the physical environment,	0 800		

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0 800	Continued From page 25 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On January 24, 2023, between 10:00 a.m. and 1:00 p.m., survey staff toured the facility with the maintenance coordinator (MC)-D. During the facility tour, survey staff observed that a door marked as an exit on the evacuation map in cottage 4 led to a courtyard enclosed by a fence. A padlock was installed on the exterior side of the fence gate. This deficient condition was verified by MC-D accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 800		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under	0 820		

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0 820	Continued From page 26 chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. 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 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: On January 24, 2023, between 10:00 a.m. and 1:00 p.m., survey staff toured the facility with the maintenance coordinator (MC)-D. During the facility tour, survey staff observed the following in the Haven Cottage: 1. Deadbolt locks were installed on marked exit doors.	0 820		

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0 820	Continued From page 27 2. A space heater was being used in a dementia care resident's sleeping room. This deficient condition was verified by MC-D accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
0 950 SS=E	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 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	0 950		

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0 950	Continued From page 28 name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to designated representative with the required verbiage on a document separate from the contract for four of six residents (R2, R5, R6 and R7). 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 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: R2, R5, R6 and R7's records lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."	0 950		

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0 950	Continued From page 29 R2 The second page of R2's Resident Agreement (contract) dated May 12, 2022, contained the required space for the name and contact information of the designated representative and a line the resident would initial if the resident declined to name a designated representative. The Resident Agreement indicated two designated representatives, but lacked the verbatim notice as required. R5 The second page of R5's Resident Agreement (contract) dated December 1, 2021, contained the required space for the name and contact information of the designated representative and a line the resident would initial if the resident declined to name the designated representative. The Resident Agreement indicated one designated representative, but lacked the verbatim notice as required. R6 Page 22 of R6's Resident Agreement (contract) dated August 12, 2021, indicated a Resident's Designated Representative, but lacked the contact information of the designated representative and a line the resident would initial if the resident declined to name the designated representative. The Resident Agreement lacked the verbatim notice as required. R7 The second page of R7's Resident Agreement (contract) dated December 1, 2021, contained the required space for the name and contact information of the designated representative and a line the resident would initial if the resident declined to name the designated representative.	0 950		

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0 950	Continued From page 30 The Resident Agreement indicated one designated representative, but lacked the verbatim notice as required. On January 26, 2023, at 4:30 p.m. licensed assisted living director (LALD)-A stated the licensee has been working through all of the resident contracts to correct this area, but have not updated all records to date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01060 SS=E	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and	01060		

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01060	Continued From page 31 (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for two of six residents (R6, 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, 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	01060		

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01060	Continued From page 32 found to be pervasive). The findings include: R6 R6 was admitted to assisted living services on August 2, 2021. R6's Service Plan dated October 10, 2022, indicated R6 received services to include medication administration, suprapubic catheter management, bathing, dressing, grooming, behavior redirection/assurance, life enrichment programming, mobility assistance with Broda chair (a high backed specialized chair which provides full body and lateral support), and two person assist with hoyer (mechanical lift) transfers. R6's progress notes indicated the following entries: -November 20, 2022, Resident left via ambulance at 9:40 p.m. to St. Mary's ER (emergency room) for catheter placement and evaluation. -November 20, 2022, 11:29 p.m.-St Mary's ER MD called to get report on resident, he stated resident has developed a fever, requiring oxygen and appears to have had a stroke. He is going to call resident's wife in regards to confirm his DNR/DNI [do not resuscitate/do not intubate] status code and make a plan from there. -November 21, 2022, 3:23 p.m.-St. Mary's social work called with usual return to cottage questions. She doesn't know his condition or when he will return. -November 22, 2022, 1:10 p.m.-Spoke with registered nurse [RN] from St. Mary's who is caring for [R6]. At this time, the hospital plans to discharge [R6] Monday November 28, 2022. -November 25, 2022, 10:02 a.m.-Call from Social	01060		

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01060	Continued From page 33 worker at St. Mary's Hospital, and he reported that [R6] will be discharge on November 28, 2022, at 10:00 a.m. and [transportation company] will transport him to the facility. -November 28, 2022, 11:09 a.m.-[R6] returned from St. Mary's via [transportation company]. We assisted him into bed and positioning on his right side. Suprapubic catheter is in place, catheter is draining yellow urine. Hospice is here to readmit. R6's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R6's records lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. R4 R4 diagnoses included unspecified dementia with behavioral disturbance, dysphagia (difficulty swallowing), and hyperlipidemia (high cholesterol).	01060		

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01060	Continued From page 34 R4 started receiving services from the licensee on September 30, 2022, to assist with medication management services and assistance with activities of daily living (ADLs). R4's progress notes indicated R4 was admitted to the hospital on November 17, 2022, at approximately 9:00 p.m. after an unwitnessed fall and discharged back to the facility on November 25, 2022, at approximately 9:00 a.m. (eight days later). R4's record lacked a written notice that contained, at a minimum: - the reason for the relocation. - the name and contact information for the location to which the resident has been relocated and any new service provider. - contact information for the Office of Ombudsman for Long-Term Care. -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known. - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R4's records lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On January 26, 2023, at 2:39 p.m. RN-B confirmed R4 did not have an emergency relocation documentation since they had not	01060		

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01060	Continued From page 35 started the process until 2023. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct a	01620		

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01620	Continued From page 36 comprehensive reassessment for four of six residents (R6, R7, R2, R3) with a change of condition and lacked accurate wound assessment information (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: R6 R6's diagnoses included dementia, major neurocognitive disorder, chronic pain syndrome, hypertension, atrial fibrillation (irregular heart beat), history of deep vein thrombosis (blood clots in extremities) and pulmonary embolism (blood clot in the lungs), and peripheral neuropathy (poor circulation to the extremities with associated nerve pain). R6's Service Plan dated October 10, 2022, indicated R6 received services to include medication administration, suprapubic catheter management, bathing, dressing, grooming, behavior redirection/assurance, life enrichment programming, mobility assistance with broda chair (a high backed specialized chair which provides full body and lateral support), and two person assist with hoyer (mechanical lift) transfers. On January 24, 2023, at 10:00 a.m. registered nurse (RN)-E was observed to provide wound	01620		

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01620	Continued From page 37 care to multiple wounds located on R6's left heel, left ankle/outer leg and right ankle. RN-E stated R6's wound care was completed daily and only the licensee's nurses and hospice nurses completed the wound care. WOUND ASSESSMENT R6's Progress Notes by licensee's nurses included entries of skin wounds beginning August 13, 2022, including: - August 13, 2022: the right outer heal 3 cm [centimeters] x 2 cm darken area noted, non blanchable Right outer ankle open area 0.5 x 0.5 x 0.1, Left heel red nonblanchable area 3 cm x 2 cm. - September 14, 2022, at 10:26 a.m. read the blister on his left heel appears larger than a week ago. No drainage or redness but it does cause pain when pressure applied. New mepilex applied and then the boot. Adjusted foot rest and Broda to keep the heel floating. His wife wants us to apply ketoconazole cream to his groin and peri area. He has a tube in his room but not in eMAR [electronic medical record]. It was discontinued this summer. Will contact hospice. - October 13, 2022, at 10:58 a.m. read resident has another pressure ulcer on the bottom of his left foot below his 4th & 5th toes. measuring at 3.5 cm x 2 cm and is unstageable (dark colored). - December 6, 2022, at 11:59 a.m. read some resistance when first started flushing but eased up during 2nd half of flush. Urine is amber. Catheter insertion site looks good - no redness, swelling or drainage. 2 x 2 split dressing applied after cleansing. Left heel wound has large black center and red around the edges. Cleansed, applied flagyl to wound and iodine ointment around edges. New dressing applied. He was given morphine before the dressing change.	01620		

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01620	Continued From page 38 R6's Uniform Assessment tool dated August 1, 2022, Skin section read, 1. Skin conditions: A. Skin is intact at time of assessment. R6's Uniform Assessment tool dated October 10, 2022, labeled as Quarterly and Change of condition: Skin section read, 1. Skin conditions: A. Skin is intact at time of assessment. R6's Uniform Assessment tool dated November 29, 2022, identified Reason for Assessment: E. hospitalization. Skin section read, 1. Skin conditions: A. Skin is intact at time of assessment. The licensee failed to indicate an accurate assessment of R6's wounds, failed to identify, describe and measure all active wounds within the Uniform Assessment tool and and failed to complete a change in condition with newly discovered wounds. CHANGE IN CONDITION R6's Progress Notes entered by licensee's nurses indicated the following: -August 11, 2022, at 8:37 a.m. read received order from [provider nurse practitioner] for hospice to evaluate and treat. Wife requests [hospice name]. Resident has had a significant decline since his fall on 7/31/22 [July 31, 2022]. His legs are weaker. Wife states that he is no longer interested in his cat. Resident was unable to lift his spoon yesterday and was fed by staff. Resident wants to sleep instead of visiting with his wife or playing cards. Hospice called at this time. -August 12, 2022, at 12:50 p.m. read Resident is being signed on for hospice care. No new orders at this time. -December 30, 2022, at 10:19 a.m. read At about 9 am today, staff were getting him out of bed and	01620		

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01620	Continued From page 39 into his Broda. He started shaking and jerking it looked like a seizure. It lasted about 3 minutes. When I checked him, he could only smile with his left side. Right hand grasp was very weak. He was able to answer questions with one word answers. Seemed to understand everything that was said to him. Staff fed him a little breakfast - French toast - he was able to swallow. I notified his wife and hospice. His hospice nurse saw him at 10 a.m. - he has regained his grip and smile. -January 10, 2023, at 10:29 a.m. read he needs more assistance and reminders with eating and holding his utensils. Message to RSC [unknown abbreviation] and admissions nurse. R6's record lacked a comprehensive assessment for a change in condition related to hospice enrollment on August 13, 2022, a change in condition with symptoms noted on December 30, 2022, and a change in condition with the need for staff assistance with feeding identified in January. On January 26, 2023, at 5:20 p.m. RN-B stated the licensee had two nurses assigned to complete all assessments for all of the licensee's residents. RN-B stated she was uncertain whether the RN who completed R6's assessments, saw the resident face to face, relied on written notes or information provided by R6's primary RN to complete the assessments. RN-B verified the assessments lacked the information regarding R6's wounds and stated there should have been an assessment completed with R6's change in condition. R7 R7's diagnoses included major neurocognitive disorder with behavioral disturbance, and visual hallucinations.	01620		

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01620	Continued From page 40 R7's Service Plan dated February 24, 2022, indicated R7 received services to include medication administration, skin monitoring, safety checks, stand-by assistance with bathing/toileting/grooming/dressing reminders, partial dentures, and glasses assistance. R7's MAR dated January 2023, indicated R7 received medications to include: one for mild pain, three for hypertension, one for high cholesterol, one for allergies, four for behavioral disturbance, one for depression, one for sleep, two for heartburn, one for glaucoma, and two creams for skin. On January 24, 2022, at 10:15 a.m. ULP-I stated R7 received assistance with medication administration, brushing teeth, occasional dressing assistance, assistance with showers, and has shaving assistance at a special time by a particular person due to the special needs of his beard. R7 was observed sitting in his room listening to music and was introduced to the surveyor. R7's Progress Notes included the following entries by the licensee's nurses regarding an increase in behaviors beginning August 19, 2022, to current, which included medication adjustments and behavior monitoring. In addition, R7's record included progress notes indicating small red bumps noted on the arms and stomach beginning November 6, 2022, resulting in medication changes. R7's record included comprehensive assessments completed on September 9, 2022, and December 8, 2022, labeled as "Quarterly" and on page 7. number 1. Skin conditions: A.	01620		

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01620	Continued From page 41 Skin is intact at time of assessment. The section of Physical health status 3. List any infectious conditions occurring at the time of assessment or that have occurred since previous assessment indicated H. N/A [not applicable]. The licensee failed to complete an assessment for a change in condition with R7's scabies infection. The assessment dated December 8, 2022, lacked the scabies infection history and treatment. Additionally, the licensee failed to complete an assessment for a change in condition related to R7's increased behaviors, and after several medication changes associated with behaviors. On January 26, 2023, at 5:15 p.m. RN-B stated a comprehensive assessment should have been completed for R7's change in condition related to increased behaviors and his scabies skin infection. R2 R2's diagnoses included Neurocognitive disorder, hypertension, and diabetes. R2's last assessment dated November 22, 2022, indicated it was a quarterly assessment and R2 needed assistance with toileting, activities of daily living (ADLs) and medication management. R2's resident record indicated R2 entered hospice on September 1, 2022. R2's record lacked a change of condition reassessment following admission to hospice. R3	01620		

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01620	Continued From page 42 R3's diagnoses included dementia with Lewy bodies, hypertension, and hyperlipidemia. On January 25, 2023, at 9:14 a.m. the surveyor observed two unlicensed personal (ULP) assist R3 with toileting, dressing, and grooming. R3's last assessment dated January 19, 2023, indicated it was a quarterly assessment and R3 needed assistance with toileting, transfers, dressing, and medication management. R3's record indicated R3 entered hospice on November 4, 2022. R3's record lacked a change of condition reassessment following admission to hospice. On January 25, 2023, at 1:33 p.m. RN-B confirmed the licensee's process would be to provide a change in condition assessment when entering hospice. The licensee's Initial and on-going nursing assessment policy dated August 1, 2021, indicated nursing assessments are completed by a registered nurse based upon the required assessment schedule and as needed based upon resident condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 43 (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 observation, interview, and record review, the licensee failed to ensure one of six residents' (R6) service plans were revised to reflect the current services provided. 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).	01640		

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01640	Continued From page 44 The findings include: R6's record lacked documentation the service plan was revised each time a new service was added or changed to include TED (thromboembolic deterrent) stockings, hospice services, catheter flushes and wound care. R6's diagnoses included dementia, major neurocognitive disorder, chronic pain syndrome, hypertension, atrial fibrillation (irregular heart beat), history of deep vein thrombosis (blood clots in extremities) and pulmonary embolism (blood clot in the lungs), and peripheral neuropathy (poor circulation to the extremities with associated nerve pain). R6's Service Plan dated October 10, 2022, indicated R6 received services to include medication administration, suprapubic catheter (a urinary catheter placement through the lower abdomen into the bladder) bag drainage and bag exchange, bathing, dressing, grooming, behavior redirection/assurance, life enrichment programming, mobility assistance with Broda chair (a high backed specialized chair which provides full body and lateral support), and two person assist with hoyer (mechanical lift) transfers. The Service Plan indicated use of TED stockings; however, R6's TED stockings were no longer able to be used. R6's Progress Note dated October 18, 2022, indicated okay to DC [discontinue] compression [TED] stockings. The licensee failed to remove the service treatment of TED stockings from R6's Service Plan. The licensee failed to revise R6's Service plan to include the service of hospice with each hospice	01640		

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01640	Continued From page 45 admission. R6's Progress Note dated August 12, 2022, at 12:50 p.m. read "resident is being signed on for hospice care. No new orders at this time. [R6's] Service Plan lacked the service of hospice. R6's Progress Note dated November 28, 2022, at 11:09 a.m. read [R6] returned from St. Mary's via [stretcher company]. We assisted him into bed and positioned him on his right side. Suprapubic catheter is in place. Catheter is draining yellow urine. Hospice is here to readmit. This readmission to hospice had followed a hospitalization which required the discharge from hospice services. The Service plan lacked the services of suprapubic catheter flushes and wound care by the licensee's nurses. On January 24, 2023, at 9:55 a.m. registered nurse (RN)-E was observed to flush R6's suprapubic catheter with 30 milliliters (ml) normal saline. RN-E stated "[R6's] urine had shown a great deal of sediment which had been problematic in plugging his catheter, not allowing the bladder to empty." She stated the catheter is flushed three times daily and only the licensee's nurses complete the flushes. RN-E stated the unlicensed personnel (ULP) emptied and completed urine bag exchanges as scheduled. On January 24, 2023, at 10:00 a.m. RN-E was observed to provide wound care to multiple wounds located on R6's left heel, left ankle/outer leg and right ankle. RN-E stated R6's wound care is completed daily and only the licensee's nurses and hospice nurses completed the wound care. On January 24, 2023, at 1:20 p.m. RN-E was observed to provide wound care to R6's right gluteal cleft (right buttock) wound. RN-E stated	01640		

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01640	Continued From page 46 R6's right gluteal wound was a recent development and the licensee and hospice had just started managing the wound care for this area. On January 26, 2023 at 5:15 p.m. RN-B verified R6's service plan had not been updated to include the provisions of wound care and suprapubic catheter flushes and stated the service of TED stockings should have been removed from the Service Plan once they were discontinued. The licensee's Contents of Service Plans Policy dated July 28, 2021, indicated Service Plans are reviewed and revised as needed based upon on-going resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of	01730		

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diversion, and consistent with the manufacturer's directions;
(3) documentation of specific resident instructions relating to the administration of medications;
(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;
(5) identification of medication management tasks that may be delegated to unlicensed personnel;
(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and
(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.
(b) The medication management record must be current and updated when there are any changes.
(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan included all required content for six of six residents (R5, R6, R7, 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, but was not likely to

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01730	Continued From page 48 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: R5 R5's diagnoses included intellectual developmental delay, asthma, and incontinence (inability to control bladder/bowel). R5's Service plan dated November 29, 2022, indicated R5 received medication administration. On January 24, 2023, at 9:40 a.m. ULP-I stated R5 had received her medications earlier in the morning. R5's eMAR (electronic medication record) dated January 2023, indicated R5 received medications to include three medications for asthma, two supplements, one for nasal dryness, one for a hormone replacement, two for constipation, one for dandruff, one for insomnia, one for facial rosacea (a skin condition that causes blushing or flushing and visible blood vessels in your face. It may also produce small, pus-filled bumps), two for dry skin, three for mild pain, and one wound care dressing for as needed treatment for any reddened area on her bottom. R5 Medication/Treatment/Therapy Plan integrated within the R5's Service Plan dated November 29, 2022, indicated the licensee was managing R5's medications and treatment services. R5's orders dated December 1, 2021, indicated	01730		

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01730	Continued From page 49 the following medications for pain/fever: -acetaminophen 160 mg (milligrams) chew, take four 160 mg tablets (to equal 640 mg) every six hours as needed; -acetaminophen 160 mg/5 ml (milliliters) liquid, take 20 ml (640 mg) every eight hours as needed; -acetaminophen 500 mg tablets, take two 500 mg tablets (to equal 1000 mg) three times daily as needed; -aspirin 81 mg chewable tablet, chew and swallow four tablets (324 mg) by mouth once daily as needed for pain/fever; and -ibuprofen 200 mg tablet, take 1-2 tablets (200-400 mg) by mouth every six hours as needed for pain/fever. R5's record lacked the direction for the ULP to know which medication for pain/fever should be used and when. Additionally, R5's order for ibuprofen indicated a range of 1-2 tablets and failed to indicate clear direction for ULP to determine dosing. R5's medication order dated December 1, 2021, indicated the following medications for wheezing or shortness of breath: -albuterol HFA 90 MCG (micrograms)/ACT inhaler, Inhale two puffs by mouth every four hours, as needed for wheezing or shortness of breath, -ipratropium albuterol 0.5-3 mg/3 ml, inhale one vial via nebulizer two times daily as needed for wheezing or shortness of breath, R5's record lacked the direction for the ULP to know which medication for wheezing or shortness of breath should be used first or second. On January 26, 2023, at 5:00 p.m. registered nurse (RN)-B reviewed R5's eMAR and R5's	01730		

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orders and stated, "It makes sense that this is an issue. The Tylenol, aspirin and ibuprofen orders are very confusing and the ULP cannot assess which medication would be appropriate to give. Ibuprofen should not have a range of one-two tablets, again ULP cannot determine this dose. The ULP would not know from the eMAR as written which PRN breathing medication (inhaler or nebulizer) should be used first or second. The nurse's in charge of each cottage enter the medication orders into the eMAR, we will need to review the need to monitor orders and eMARS more closely."

R6
R6's diagnoses included dementia, major neurocognitive disorder, chronic pain syndrome, hypertension, atrial fibrillation (irregular heart beat), history of deep vein thrombosis (blood clots in extremities) and pulmonary embolism (blood clot in the lungs), and peripheral neuropathy (poor circulation to the extremities with associated nerve pain).

R6's Service Plan dated October 10, 2022, indicated R6 received services to include medication administration.

On January 24, 2023, at 8:55 a.m. ULP-F and hospice massage therapist (HMT)-G were observed to assist R6 with changing an incontinence brief and completed dressing R6's lower body. The hospital bed had upper bed rails on both sides of the hospital bed. ULP-F and HMT-G transferred R6 to the broda chair with the use of a hoyer lift.

R6'S Medication/treatment/therapy plan and assessment dated October 10, 2022, indicated the licensee was managing R6's medication

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COTTAGEWOOD SENIOR COMM	4310 55TH STREET NW ROCHESTER, MN 55901

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01730	Continued From page 51 administration. R6's eMAR dated January 2023, indicated he received medications to include one medication for wound infection, two for skin rash, one for sleep, one for depression, one for bladder spasms, two for skin dryness and protection, one for indigestion, two for mild pain, one for constipation, one for nausea, one for excessive secretions, two PRN for constipation, two for anxiety/agitation, and one for abdominal gas pain. R6's orders dated November 28, 2022, indicated the following PRN medications for anxiety/agitation: -Lorazepam 0.5 mg every four hours PRN for anxiety -Seroquel 100 mg, give one tablet at bedtime as needed for agitation R6's record lacked the instruction for which medication should be used first or second, and lacked the description of R6's symptoms of anxiety or agitation. R6's orders dated November 28, 2022, indicated the following PRN medications for constipation: -docusate sodium 100 mg, one capsule orally daily as needed, -Miralax powder, dissolve 17 gms (grams) in water and take by mouth as needed, -Senna S 50 mg-8.6 tablet, take two tablets by moth at bedtime as needed, R6's record lacked direction for the ULP to know which medication should be used first when R6 had constipation. On January 26, 2023 at 5:40 p.m. RN-B reviewed R6's eMAR and stated her agreement for the	01730		

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01730	Continued From page 52	01730		

need of clarification of when and which medications would be used, and stated ULP cannot assess to determine this. RN-B stated R6 has not used the Seroquel since it had been ordered.

R7
R7's diagnoses included major neurocognitive disorder with behavioral disturbance, visual hallucinations, type two diabetes, hypertension (high blood pressure), insomnia, urinary frequency, and unspecified headaches.

R7's Service Plan dated February 24, 2022, indicated R7 received services to include medication administration.

On January 24, 2022, at 10:15 a.m. ULP-I stated R7 received assistance with medication administration.

R7's Medication Management Plan dated February 22, 2022, indicated the licensee was managing medication services for R7.

R7's MAR dated January 2023, indicated R7 received medications to include: one for mild pain, three for hypertension, one for high cholesterol, one for allergies, four for behavioral disturbance, one for depression, one for sleep, two for heartburn, one for glaucoma, and two creams for skin.

R7's provider order dated August 15, 2022, read Trazodone 25 mg by mouth once daily in the morning and 50 mg at HS [bedtime] and 50 mg by mouth as needed. R7's record lacked the number of times each day R7 could receive the PRN doses, how many hours between doses, and what symptoms R7 exhibited where the ULP

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01730	Continued From page 53 would recognize the need to administer. R7's provider order dated August 25, 2022, read quetiapine 25 mg one tablet orally three times daily (TID) as needed. R7's record lacked the description of how many hours between doses and what symptoms R7 exhibited for the ULP to recognize the need to administer. Additionally, R7's record lacked the direction to indicate when the ULP should administer quetiapine verses Trazodone. On January 26, 2023, at 5:25 p.m. RN-B stated she understood the need to distinguish dose spacing, adding Trazadone does not always manage R7's anxiety, and there is a need to specify which medication is used and for what symptoms. Additionally, R5, R6, and R7's medication plans lacked the required delegated medication tasks for ULP for all residents. R2 R2's diagnosis included Neurocognitive disorder, hypertension and diabetes. R2's service agreement dated August 26, 2022, indicated R2 received services to include medication administration. R2's EMAR dated January 2023, indicated R2 received medications for pain, medication for tremors, two medications for dementia, medication for depression, and medication for hypertension. R2's Medication management plan dated May 12,	01730		

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01730	Continued From page 54 2022, indicated medication administration will be provided by the agency unlicensed staff, agency RN, and agency licensed practical nurse (LPN). The medication management plan indicated the agency RN/LPN will monitor supplies and order refills. The Medication management plan failed to indicate the identification of which medication management tasks that may be delegated to unlicensed personnel (ULP). R3 R3's diagnosis included dementia with Lewy bodies, hypertension, and hyperlipidemia (high cholesterol). R3's service agreement dated October 17, 2022, indicated R3 received services to include medication management. R3's EMAR dated January 2023, indicated R3 received medications for pain, medication for hyperlipidemia, for allergies, three medications for agitation and depression, and for sleep. R3's Medication management plan dated October 17, 2022, indicated medication administration will be provided by the agency unlicensed staff, agency RN, and agency LPN. The medication management plan indicated the agency RN/LPN will monitor supplies and order refills. The Medication management plan failed to indicate the identification of which medication management tasks that may be delegated to unlicensed personnel (ULP). R4 R4's diagnosis included unspecified dementia, dysphagia, hyperlipidemia, and abnormal weight	01730		

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01730	Continued From page 55 loss. R4's service agreement dated September 30, 2022, indicated R4 received medication management. R4's EMAR dated January 2023, indicated R4 received medications for heart disease, two vitamin supplements, for dementia, for pain, and for anxiety. R4's Medication management plan dated September 30, 2022, indicated medication administration will be provided by the agency unlicensed staff, agency RN, and agency LPN. The medication management plan indicated the agency RN/LPN will monitor supplies and order refills. The Medication management plan failed to indicate the identification of which medication management tasks that may be delegated to ULP. On January 25, 2023, at 1:50 p.m. RN-B confirmed the medication plan did not include which services could be delegated to the ULP. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated July 28, 2021, read the RN may delegate to unlicensed personnel the task of providing assistance with self -administration of medications or may delegate administration of medications, treatment and therapy if the unlicensed personnel have satisfied the training requirements listed above if: a. Before performing the procedures, the RN has instructed the unlicensed personnel in the proper methods to administer the medications, treatment and therapy and the unlicensed personnel have demonstrated the ability to competently follow the	01730		

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01730	Continued From page 56 procedures; b. The RN has developed written, specific instruction for each resident c. The RN has communicated with the unlicensed personnel about the individual needs of the resident; and d. The RN has documented that the unlicensed personnel have been trained and have demonstrated competency to follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement policies and procedures for giving accurate and current medications for those residents who received	01780		

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01780	Continued From page 57 medication management services during planned/unplanned times away from home. This has the potential to affect all 138 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 23, 2023, at approximately 10:30 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed all 138 residents who resided at the facility received medication management services. On January 26, 2023, at 12:25 p.m. RN-B stated she was responsible for the medication training which included medication on planned times away and it was a delegated function to the unlicensed personal (ULP). RN-B confirmed that ULP-C and ULP-H's files did not show evidence they had been trained in medication management with planned times away. The licensee's Medications for a resident who will be away from home policy dated January 2014, indicated the RN may delegate this task to unlicensed staff if the RN has trained and competency tested the unlicensed staff on procedures to follow when giving medications to clients who will be away from home when medications are scheduled.	01780		

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01780	Continued From page 58 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01780		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to renew prescriptions at least every 12 months for one of six residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R5 R5's began receiving services on December 1, 2021. R5's Service plan dated November 29, 2022, indicated R5 received medication administration.	01830		

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01830	Continued From page 59 On January 24, 2023, at 9:40 a.m. ULP-I stated R5 received her morning medications earlier in the morning. R5's medication administration record (MAR) dated January 1 through January 23, 2023, included the following medications: - budesonide 0.25 mg/ml (milligrams/milliliter) by nebulizer twice daily; - Centrum multivitamin one chew once daily (supplement); - deep sea 0.65% nasal spray, one spray to both nostrils twice daily; - estradiol one mg tablet, give half a tablet daily (hormone replacement); - head and shoulders shampoo, to wash hair every other day for dandruff; - melatonin five (5) mg, 1 tablet orally at bedtime to promote sleep; - metonidazole 0.75% cream, topically to affected areas twice daily for fungus; - multivitamin women tabs-one tablet daily; - miralax powder, dissolve 17 gm (grams) in water and take by mouth daily; - vanicream topically to affected areas daily; - vanicream Z-bar 2%, use to wash twice daily; - acetaminophen 160 mg chew, take four 160 mg tablets (to equal 640 mg) every six hours as needed for pain; -acetaminophen 160 mg/5 ml liquid, take 20 ml (640 mg) every eight hours as needed; -acetaminophen 500 mg tablets, take two 500 mg tablets (to equal 1000 mg) three times daily as needed; -albuterol HFA 90 MCG (micrograms)/ACT inhaler, Inhale two puffs by mouth every 4 hours, as needed for wheezing or shortness of breath; -aspirin 81 mg chewable tablet, chew and swallow four tablets (324 mg) by mouth once daily as needed for pain/fever;	01830		

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01830	Continued From page 60 -ibuprofen 200 mg tablet, take 1-2 tablets (200-400 mg) by mouth every six hours as needed for pain/fever; -ipratropium albuterol 0.5-3 mg/3 ml, inhale one vial via nebulizer two times daily as needed for wheezing or shortness of breath; -mepilex border 4 x 4 dressing, apply mepilex to bottom as needed. Can be left on for three days; and -Milk of Magnesia 1200 mg/15 ml, take 15 ml by mouth every 3-4 days if no bowel movement. The licensee provided a medication list which included the above listed medications signed by R5's provider dated on December 1, 2021. On January 26, 2023, at 5:00 p.m. registered nurse (RN)-B stated she would need to look through R5's record again to confirm the orders had not been renewed. On January 27, 2023, at 10:00 a.m. RN-B verified via email message, R5's medication renewal had exceeded the 12 month renewal period . The licensee's Requesting and Receiving Medication Prescription and Refills policy dated July 28, 2021, indicated the nurse would assure that the prescriber renews a medication prescription at least every 12 month, or more frequently if determined necessary based on the nursing assessment. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880		

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01880	Continued From page 61 substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to the manufacturer's recommendations in one of two medication refrigerators 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: On January 24, 2023, at 10:30 a.m. the surveyor reviewed the medication refrigerator located in the locked medication room of cottage number eight with unlicensed personnel (ULP)-C. Inside the refrigerator contained the following medications: - one bottle of lorazepam (used for anxiety); - one bottle of hydromorphone (used for pain); and - bisacodyl suppositories (stimulate a bowel movement) The temperature of the refrigerator was observed to be 40 degrees Fahrenheit (F). The surveyor reviewed the refrigerator temp log that indicated 15 days in January had recorded temperatures,	01880		

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01880	Continued From page 62 nine dates were left blank. Four of the 15 days had recorded temps outside the safety range for the medication. ULP-C indicated that after morning narcotic count, the temperature of the refrigerator is usually recorded. ULP-C confirmed the log was missing recorded dates. On January 24, 2023, at approximately 1:30 p.m. licensed assisted living director (LALD)-A confirmed some temperatures were out of range and that some dates were missing on the temperature log. LALD-A stated they have trouble with build-up of ice in the refrigerators that messes with the temperatures. The manufacturer guidelines for lorazepam dated April 2022, indicated the medication should be stored at a temperature of 36-46 degrees F. The manufacturer guidelines for hydromorphone dated August 2020, indicated the medication should be stored covered in the carton at 68-77 degrees F. The manufacturer guidelines for bisacodyl suppositories dated February 2010, indicated the medication should be stored at 59-86 degrees F. The licensee's January 2014, Storage of Medication policy indicated the registered nurse (RN) will identify how medications will be secured and under proper temperature controls. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01890	Continued From page 63	01890		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to label time sensitive medications with an opened date for two of two residents (R13, R14). 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: On January 24, 2023, at 11:25 a.m. the evaluator and unlicensed personnel (ULP)-I reviewed the contents of Cottage seven's medication cart and the following was observed to lack an opened date: -R13- Novolin flexpen 100 units/ml (milliliters)-one flexpen -R13 - Novolin 70/30 flexpen-one flexpen -R14- Timolol eye drops-one bottle ULP-I stated she usually remembered to indicate the open date for the medications requiring an	01890		

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01890	Continued From page 64 open date indication. ULP-I stated she was not aware novolin pens could not be used 28 days after they were opened for use. Novolin Flex pen 100 units/ml package insert dated November 2022, indicated In-use (opened) room temperature-28 days up to 86 degrees Fahrenheit Novolin 70/30 package insert dated June 2018, indicated "In use room temperature-28 days." Timolol eye drops-package label for storage indicated "unused units in the pouch at room temperature, protect from freezing, protect from light. Use within one month after the foil package has been opened. On January 24, 2023, at 3:25 p.m. licensed assisted living director (LALD)-A stated "nursing should be auditing the medication carts in each cottage to ensure the medications requiring open date indication are properly completed." The licensee's Storage of Medications policy dated July 28, 2021, read until the medication is set up for immediate or later administration by a nurse, the medication must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01890		

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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
01940	Continued From page 65	01940		
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 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include on the service plan a written statement of the treatment	01940		

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	20391	A. BUILDING: _____ B. WING _____	01/26/2023

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01940	Continued From page 66 or therapy services provided for one of six residents (R5) receiving 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, 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: R5's Service plan dated November 29, 2022, indicated R5 received services to include medication administration, glasses assistance, skin integrity checks, life enrichment programming, two person assistance with bathing and dressing, right foot brace, one person assistance grooming, oral care and eating, one person assist with wheelchair mobility and two person assist with toileting, transfers and with any gait belt and walker use. On January 24, 2023, at 9:40 a.m. R5 was observed to have a front laced brace on her right foot. The brace extended above her right ankle. R5's Treatment Therapy Plan dated November 29, 2022, indicated the treatment of a mechanical soft diet, but lacked the use of a right foot brace. On January 26, 2023, at 4:45 p.m. registered nurse (RN)-B verified R5's treatment plan lacked R5's right foot brace. The licensee's Individualized Medication, Treatment and Therapy Management Plans	01940		

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01940	Continued From page 67 policy dated May 24, 2022, indicated the RN would develop a treatment and therapy management plan for each resident receiving treatment and/or therapy management services. The treatment and therapy management plan would include: a. Statement of the type of service(s) provided b. Documentation of specific resident instructions relating to the treatments and/or therapy administration c. Identification of treatment or therapy tasks that may be delegated to an unlicensed staff member. d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments and/or therapy services e. 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 and/or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as	01960		

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01960	Continued From page 68 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 treatment or therapies were administered as directed, or to document the reason they were not administered, for one of six residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). R6's Service Plan dated October 10, 2022, indicated R6 received services to include suprapubic catheter management. R6's Service Plan lacked the service of wound care. R6's wound care order dated December 3, 2022, indicated start Flagyl 375 mg, sprinkle in left foot wound daily (wound care). R6's wound care order dated December 5, 2022, indicated cleanse wound with NS [normal saline], pat dry with gauze, apply iodosorb, cover with gauze and Kerlix dressing [a cling like wrap to hold dressings/gauze in place], change daily and PRN [as needed] if soiled. Hospice and facility to complete care. R6's suprapubic catheter flush order dated	01960		

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01960	Continued From page 69 November 2, 2022, indicated flush catheter TID [three times daily] per nursing availability with 30 ml [milliliters] saline to assist with patency. R6's electronic medication administration record (eMAR) lacked documentation of the following wound management and catheter flush cares completed by the licensee's registered nurses: -Cadexomer iodine 0.9% gel. Apply to left heel one time dally during dressing changes. No not apply to intact skin-apply to wound bed only. Dressing Change instruction. Cleanse with normal saline and 4 x 4 gauze. Allow to dry. Apply Iodosorb to the wound bed, cover with mepilex foam (new one every three [3] days and as needed [PRN]. -missed documentation on January 14, 16, 2023; -Dressing-cleanse the area with normal saline and 4 x 4 gauze. Allow to dry. Apply Iodosorb to the wound bed daily. No NO apply to intact skin. Cover with gauze and wrap with Kerlix. Check left ankle and right foot wounds as well. Missed documentation on January 14, 16, 2023; -Flagyl 500 milligram [mg] tablet-sprinkle of left foot for wound care one time per day-missed documentation on January 5, 14, 16, 2023; and -Flush catheter-Flush suprapubic catheter three [3] times daily with 60 milliliters [ml]. Missed documentation on January 14, 2023, (morning), January 3, 4, 5, 9, 10, 11, 12, 13, 14, 2023, (2:00 p.m.), January 5, 13, 14, 15, 16, 17, 2023 (8:00 p.m.). R6's Progress Notes indicated an inability to flush his suprapubic catheter with entries as follows: - January 16, 2023, at 10:55 a.m. indicated "attempted flush of his catheter but it wasn't patent. I moved the catheter around to make sure it wasn't kinked and tried again but wasn't able to flush. I called hospice to inform them";	01960		

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01960	Continued From page 70 - January 16, 2023, at 1:49 p.m. indicated "His hospice nurse was able to get his catheter flushed."; -January 17, 2023, at 10:55 a.m. indicated "Changed dressing on left heel and left outer ankle per instructions. Attempt made to flush catheter, but not able to. Checked for kinks and changed the position but resisted flush. 200 cc output at 0619 today. Will contact hospice."; -January 17, 2023, 11:09 a.m. indicated "Will try catheter flush when he's in bed this afternoon. If this doesn't work, I will contact hospice again."; -January 17, 2023, at 1:32 p.m. indicted "LRA [lead resident assistant] assisted me in getting him from Broda to bed. Tried flushing his catheter while he was on his back and again while he was on his left side but wasn't able. Notified hospice. She will see him shortly."; -January 17, 2023, 2:14 p.m. indicated "His [R6] hospice nurse wasn't able to flush his catheter either. We will send him in to Mayo ED [emergency department]. I called 911 non-emergent at 14:10 - they are sending an ambulance. His hospice nurse called [R6]'s wife and will call St. Mary's admission/transfer line."; -January 17, 2023, 1:32 p.m. indicated "Mayo Ambulance arrived at 14:40. Gave report. Staff and paramedics transferred to gurney. They will transport to ED"; and -January 18, 2023, 9:07 a.m. indicated "He returned to Cottage 7 last evening after having his catheter changed. Mayo ED staff weren't able to flush either. His wife didn't go to the ED but talked to [R6] on the phone. She is here this morning to visit." On January 24, 2023, at 9:55 a.m. registered nurse (RN)-E was observed to flush R6's suprapubic catheter with 60 ml of normal saline. RN-E stated "R6's urine has had a great deal of	01960		

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01960	Continued From page 71 sediment in it and often plugs the catheter. We've [the licensee] has been dealing with it for quite some time and R6 has had to go in [to the emergency room] to have the catheter exchanged even recently. Only the nurses are flushing the suprapubic catheter line. I've probably missed some documentation stating it was completed." On January 26, 2023, at 5:35 p.m. RN-B stated "The wound cares and catheter flushes should have been documented in the eMAR, but would note the RN had some documentation within the nurses notes." The licensee's Documentation of Medication, Treatment and Therapy Management Services dated July 28, 2021, indicated RNs, LPNs, and ULP will appropriately document all medications, treatments, and therapy management services provided to residents including documentation of PRN medications and documentation of requesting and receiving prescription refills. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.	01970		

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01970	Continued From page 72 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for two of six residents (R5, R6) receiving 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, 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 January 23, 2023, at 11:30 a.m. licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the licensee provided treatment and therapy services to the licensee's residents. R5 R5's diagnoses included intellectual developmental delay, asthma, and incontinence (inability to control bladder/bowel). R5's Service plan dated November 29, 2022, indicated R5 received services to include skin integrity checks, two person assistance with bathing and dressing, right foot brace. R5's Service Check off Sheet dated January 2023, indicated R5 received dressing assistance of two personnel. Please allow her to choose	01970		

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01970	Continued From page 73 between two outfits. Ensure she is wearing clean, dry, matching, weather appropriate clothing. [R5] has a brace for her right foot. This is to be worn any time that she is up in her chair. Report to nursing with any concerns. On January 24, 2023, at 9:40 a.m. R5 was observed to have a front laced brace on her right foot. The brace extended above her right ankle. The licensee failed to obtain an order for R5's right foot brace. On January 26, 2023, at 4:45 p.m. registered nurse (RN)-B verified R5's record lacked prescriber orders for a right foot brace. R6 R6's record lacked an order for wound care to right gluteal cleft (buttock area). R6's diagnoses included dementia, major neurocognitive disorder, chronic pain syndrome, hypertension, atrial fibrillation (irregular heart beat), history of deep vein thrombosis (blood clots in extremities) and pulmonary embolism (blood clot in the lungs), and peripheral neuropathy (poor circulation to the extremities with associated nerve pain). R6's Service Plan dated October 10, 2022, indicated R6 received services to include medication administration, suprapubic catheter management, bathing, dressing, grooming, behavior redirection/assurance, life enrichment programming, mobility assistance with broda chair (a high backed specialized chair which provides full body and lateral support), and two person assist with hoyer (mechanical lift)	01970		

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01970	Continued From page 74 transfers. R6's Service Plan lacked the service of wound care. R6's eMAR dated January 2023, indicated Dressing Change and Treatment started by licensee on January 20, 2023, for the time of 1:00 p.m. daily, with direction that included "Check the wound on his buttocks. Cleanse and change dressing." R6's progress notes included entries by the licensee's RN's as follows: -January 13, 2023 at 9:18 a.m.-Despite daily wound care and dressing changes by LRAs [lead resident assistants], the open area on his right buttock is large and has a foul odor. May need to have him spend more time in bed on his sides during the day. Will talk to hospice. -January 13, 2023, at 11:06 a.m. Notified hospice of the appearance and odor of the buttocks wound. Also let them know the right ankle wound that was found last evening. Let nurse know that I haven't noticed an odor from his left foot lately. He was given morphine prior to the dressing change this morning but he still complained of pain. Slight resistance when flushing the catheter. There is large amount of white sediment in his urine. -January 15, 2023, at 1:22 p.m.-Nurse did all of resident's wound dressing changes-coccyx/Rt [right] gluteal, left heel and outer leg, and right outer foot X [times] two. Cath [catheter] flush performed with slight resistance. Writer called hospice to request more Mepilex borders for resident's multiple wounds. Hospice stated they will have his visiting nurse come with supplies. -January 20, 2023 at 3:13 p.m.-Nurse called hospice to see if they were going to be coming out this afternoon so that wound cares could be coordinated with writer and hospice. Resident	01970		

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01970	Continued From page 75	01970		

already had his quota for the week of nurse visits. Hospice nurse replied that they have been involved with all the wound cares and document their measurements within their system. Hospice stated they requested for ED staff to assess resident's coccyx/gluteal wound when resident was sent in on Tuesday the 17th. Hospice explained they were the one to call report in to the ED staff on the 17th, but then hospice said they don't think the wounds got addressed or evaluated in the ED. At this point, hospice suggests to keep resident off his bottom as much as possible. Writer wrote log for staff awareness.

Hospice Visit Communication note dated January 13, 2023, written by hospice aide, read "Pt [patient] was in Broda [high back specialized chair] in room. Assisted with feeding, socialized, refused nail care, namaste cares completed, looks and sounds sick. Hospice RN notified, new pressure sores, complaining of pain. Notified [R6]'s wife."

Hospice Visit Communication dated January 16, 2023, hospice RN written note read "Pt [patient] put into bed shortly after I arrived. He denied pain and not SOB [shortness of breath] noted. L [left] heel wound changed, wound on bottom changed and R [right] heel wound changed. All cleansed, Morphine given for pain while here and Pt is now sleeping well."

On January 24, 2023, at 1:20 p.m. RN-E was observed to complete wound care to R6's right gluteal cleft (buttock) wound. She was observed to remove the previous dressing, cleanse the wound with a saline wound spray and apply a large mepilex dressing (a padded dressing with adhesive edges) over the wound site. RN-E stated "Hospice has been helping with this too,

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01970	Continued From page 76 however, I do not have specific orders or directions for this wound." On January 25, 2023, at 5:30 p.m. RN-B stated she would follow up with the RN working with R6 and with hospice to obtain the proper order for his gluteal wound care/dressing. The licensee's Renewal of Medication, Treatment or Therapy Prescriptions and Orders dated August 23, 2021, indicated a medication prescription of a treatment or therapy order must be current and must be renewed at least every twelve (12) months. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
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	02170		

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02170	Continued From page 77 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 conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan with all the required content based on the evaluation, for five of five residents (R5, R7, R2, R3, R4) who received services under an assisted living with dementia care license. 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 the potential to	02170		

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02170	Continued From page 78 affect a large portion or all the residents). The findings include: R5 R5's diagnoses included intellectual developmental delay, asthma, and incontinence (inability to control bladder/bowel). R5's resident agreement dated December 1, 2021, indicated R5 started receiving services under the licensee's assisted living with dementia care license. R5's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility. R5's undated, activity plan was missing required elements. The following items were missing in the activity plan: -adaptations necessary for the resident to participate; and -activities which may be used as behavioral interventions R7 R7's diagnoses included major neurocognitive disorder with behavioral disturbance, visual hallucinations. R7's contract dated February 24, 2022, indicated R7 began receiving services under the licensee's assisted living with dementia care license. R7s record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility. R7's undated, activity plan was missing required elements. The following items were missing in the activity plan: - emotional and social needs and patterns; and - cognition	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20391	A. BUILDING: _____ B. WING _____	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGEWOOD SENIOR COMM	4310 55TH STREET NW ROCHESTER, MN 55901

(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 79 R2 R2 diagnoses included Neurocognitive disorder. R2 started receiving services from the licensee on May 12, 2022, to assist with medication management services including medication set-up and medication administration and assistance with activities of daily living (ADLs). R2's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility. R2's undated, activity plan was missing required elements. The following items were missing in the activity plan. - past interests; and - emotional and social needs and patterns R3 R3's diagnoses included dementia with Lewy bodies. R3 started receiving services from the licensee on October 17, 2022, to assist with medication management services to include medication set-up and medication administration and assistance with ADLs. R3's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility. R3's undated, activity plan was missing required elements. The following items were missing in the activity plan: - past interests; - current abilities and skills; - emotional needs and patterns; and - physical abilities and limitations R4 R4 diagnoses included unspecified dementia with	02170		

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	20391	A. BUILDING: _____ B. WING _____	01/26/2023

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02170	Continued From page 80 behavioral disturbance. R4 started receiving services from the licensee on September 30, 2022, to assist with medication management services to include medication set-up and medication administration and assistance with ADLs. R4's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility. R3's undated, activity plan was missing required elements. The following items were missing in the activity plan: - emotional needs and patterns; and - physical abilities and limitations On January 26, 2023, at 4:32 p.m. licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the activity plans were undated and had missing fields. The licensee's Description of Life Enrichment Programs and how Activities are Implemented in ALDC (assisted living with dementia care) policy dated October 26, 2021, indicated It is the policy of our community to provide a selection of daily activities based on individual and group interests. Individual and group activities will be planned, as well as structured and nonstructured activities. Opportunities for outdoor time and for engagement with the broader community will be facilitated for those interested. Each resident receiving assisted living services will be evaluated for activities. The evaluation must include: a. Past and current interests b. Current abilities and skills c. Emotional and social needs and patterns d. Physical abilities and limitations e. Adaptations necessary for the resident to	02170		

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	20391	A. BUILDING: _____ B. WING _____	01/26/2023

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02170	Continued From page 81 participate, and f. Identification of activities for behavioral interventions No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of two residents (R6) with bed rails. This resulted in an immediate correction order on January 25, 2023. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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:	02310		

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02310	Continued From page 82 R6 R6's diagnoses included dementia, major neurocognitive disorder, chronic pain syndrome, hypertension, atrial fibrillation (irregular heart beat), history of deep vein thrombosis (blood clots in extremities) and pulmonary embolism (blood clot in the lungs), and peripheral neuropathy (poor circulation to the extremities with associated nerve pain). R6's Service Plan dated October 10, 2022, indicated R6 received services including medication administration, suprapubic catheter management, bathing, dressing, grooming, behavior redirection/assurance, life enrichment programming, mobility assistance with broda chair (a high backed specialized chair which provides full body and lateral support), and two person assist with hoyer (mechanical lift) transfers. On January 24, 2023, at 8:55 a.m. unlicensed personnel (ULP)-F and hospice massage therapist (HMT)-G were observed to assist R6 with changing an incontinence brief and dressing R6's lower body. R6's bed had upper bed rails on both sides of the bed. Additionally, during treatment observations at 9:55 a.m. and 2:15 p.m., bed rails on R6's bed were observed in the up position. On January 24, 2023, at 2:15 p.m. registered nurse (RN)-E was observed to complete wound care for R6's right gluteal cleft pressure wound. R6 was positioned on his right side and was observed to hold on to the upper bed rail. Two ULP were at the bedside and observed to provide additional support in holding R6 in position during the wound care.	02310		

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02310	Continued From page 83	02310		

R6 's nurse progress notes included:
- dated August 13, 2022, read "resident [R6] is being signed on for hospice. No new orders at this time."
- dated September 6, 2022, read "Writer called hospice to see if we could get a different bed for resident as his feet rest at the very end of the bed. Hospice will order a bed that is longer and has wheels to move easier for cares. Writer asked if hospice could order a broda chair as well."
- dated October 4, 2022, read "[R6's] wife called to confirm the plan to insert catheter on Thursday, October 6, at 11:00 a.m. I told her that I'd talked to his hospice nurse yesterday and we'll be there. She also wants to have the bedrails (that are in his closet) put on his bed. She is aware that there is paperwork that needs to be done."

R6's record lacked the required bed rail assessment, hospital bed rail measurements and education to the resident regarding the risks verses benefits of bed rail use.

On January 25, 2023, at 8:57 a.m. registered nurse (RN)-B communicated via an email which read, "Unfortunately, [R6] should NOT have had bedrails on. The hospital bed came with them, and we had removed them. We realized early this morning that we had not authorized them to be put back on, nor had there been any paperwork filled out by his POA [Power of Attorney]. They have been removed."

On January 25, 2023, at 11:15 a.m. licensed assisted living director (LALD)-A stated the bed rail on R6's bed should never have been there. The hospital bed had come with the bed rails and were removed as the RN felt R6 would not be able to effectively use them. LALD-A stated she

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02310	Continued From page 84	02310		

and RN-B have a list of all residents with bed rails and had completed quarterly audits of all cottages on campus to ensure bed rails were properly secured. LALD-A stated she was uncertain as to how the bed rails were placed back onto the hospital bed. LALD-A stated the bed rails were previously kept in R6's closet.

On January 25, 2023, at 1:35 p.m. R6 was observed in bed without side rails in place.

On January 25, 2023, at 1:40 p.m. RN-B stated with the last campus walk through completed by LALD-A on December 6, 2022, R6 did not have bed rails on his bed. RN-B stated she "figured out that R6's hospice nurse placed the bed rails on R6's bed."

On January 25, 2023, at 1:45 p.m. RN-B provided the licensee's Campus Side Rail List dated December 27, 2022, which indicated there were a total of five residents with bed rails. R6 was not included on the list. Additionally, RN-B provided the licensee's Quality Improvement forms used for campus walk through completed by LALD-A and other staff. The Quality Improvement form is used to review cottage conditions and to verify the residents with bed rails and the bed rail security. The form for R6's cottage dated December 6, 2022, did not indicate R6 had a bed rail in place at that time.

The licensee's Assessing the Safety of Side rails policy dated June 24, 2021, indicated staff will alert the RN if a resident has any type of side rail or similar equipment and the RN will then evaluate whether the side rail appears to be safe for the resident. The RN will educate the resident, their representative and/or family members about the risks related to side rails, and if the resident's

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side rail does not appear to meet FDA standards, the RN will recommend to the resident, the resident representative, or the resident's involved family members that the side rail be removed and will recommend alternative options to reduce the risk of a fall out of bed. The RN will document these conversations and recommendations.

The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), zone 2 (space under the rail, between the rail supports) zone 3 (space between the rail and mattress), should be less than 4 and 3/4 inches. Zone 4 (space under the rail at the ends of the rail, between the rail and mattress) should be less than 2 and 3/8 inches.

The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe".

The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether

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02310	Continued From page 86 that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On January 26, 2023, at 11:23 a.m. the immediacy of correction order 2310 was removed; however, non-compliance remains at a scope and level of G.	02310		

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02310	Continued From page 87 TIME PERIOD FOR CORRECTION: Two (2) Days	02310		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause	03000		

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03000	Continued From page 88 (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) for a significant medication error for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 service plan dated August 24, 2022, indicated he received services to include medication administration.	03000		

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03000	Continued From page 89 The licensee's Initial Medication Incident Report dated January 5, 2023, indicated R2 had received hydromorphone HCL (a narcotic pain reliever) in a 10 mg/ml (milligram/milliliter) solution. With the dose to be 0.2 ml at 8:00 p.m. the incident form indicated the incident in detail: MA [medication assistant] gave the resident 2 [two] ml instead of giving 0.2 ml. (the dose given is 10 times the dose ordered). Observations made and instructions per HSD (health services director): Continue to monitor for adverse reactions, notified hospice nurse, notified NP [nurse practitioner], regular checks, vital signs. Immediate actions taken for resident: Followed physician's orders, instructions included in resident service notes, observations made per HSD's instruction. Final Resident Outcome: No adverse outcome Narrative of Investigation: On investigation it was noted that [R2] was given 2 ml instead of being given 0.2 ml. This caused him to become drowsy. MA immediately notified nursing of her error. Nursing called hospice who delivered a dose of Narcan. No adverse effects occurred further. Possible Contributing Factors: failure to check meds against MARS (medication administration record), failure to follow policy and procedure, frequent distractions, misread medication label. Corrective action taken: discussed 7 [seven] medication rights, discussed 3 [three] checks. The licensee failed to report the significant medication error to MAARC. On January 26, 2023, at 4:30 p.m. RN-B and LALD-A stated based off what was written, they did not feel it met the criteria for reporting to MAARC.	03000		

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03000	Continued From page 90 The licensee's Vulnerable Adult Maltreatment policy dated July 20, 2021, indicated a. Any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately to their supervisor, a nurse, or the Licensed Assisted Living Director (LALD) and that person will complete an incident report. a. If the incident appears to be suspected abuse, neglect or financial exploitation, the LALD or designee will immediately make a report to MAARC ("Immediately" means as soon as possible, but no longer than 24 hours from the time the LALD or designee received initial knowledge that the incident occurred). b. If it is unclear based whether maltreatment has occurred, an investigation into the incident will begin immediately. c. If within the 24 hours following the initial incident report, it is still unclear whether reportable maltreatment has occurred, a report will be made to MAARC. d. If it appears that a crime may have been committed, the LALD or designee will immediately contact the police if the witness has not already done so. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

DEPARTMENT OF HEALTH

Type: Full
Date: *01/23/23*
Time: 11:31:06
Report: 7920231017

Food and Beverage Establishment Inspection Report

Location:
Cottagewood Senior Comm
4310 55th Street Nw
Rochester, MN55901
Olmsted County, 55

Establishment Info:
ID #: 0037560
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072868528
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Top freezer
Temperature: 0 Degrees Fahrenheit - Location: Ice, bread, pancakes
Violation Issued: No

Process/Item: Refrigerator
Temperature: 30 Degrees Fahrenheit - Location: Milk, chocolate milk, fruit
Violation Issued: No

Process/Item: Top freezer
Temperature: -8 Degrees Fahrenheit - Location: Ice cream, juice, bkfst food
Violation Issued: No

Process/Item: Refrigerator
Temperature: 40 Degrees Fahrenheit - Location: Pasteurized eggs, milk, salad
Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: 0 Degrees Fahrenheit - Location: Main. Meat, brkfst foods, vegetables
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 33 Degrees Fahrenheit - Location: Main. Vegetables, desserts, etc.
Violation Issued: No

Type: Full
Date: *01/23/23*
Time: 11:31:06
Report: 7920231017
Cottagewood Senior Comm

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 35 Degrees Fahrenheit - Location: Employee food
Violation Issued: No

Serving kitchen in cottage 1, Eggs and limited amount of food prepared on site. Food prepared at main kitchen, delivered, and served to residents.

Cottage 9 main kitchen. Food for approximately 140 meals a day prepared in this commercial kitchen.

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

I acknowledge receipt of the inspection report number 7920231017 of 01/23/23.

Certified Food Protection Manager: Patrica M Patrick

Certification Number: FM94522 Expires: 06/15/24

Signed: _____
Establishment Representative

Signed: _____
Sam Boysen
Public Health Sanitarian
Rochester District Office
507-206-2719
samuel.boysen@state.mn.us