DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 26, 2022

Administrator
Elderwood Of Hinckley
710 Spring Lane
Hinckley, MN 55037

RE: Project Number(s) SL23986015

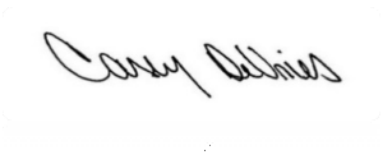
Dear Administrator:

On August 3, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the May 19, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

Electronically Delivered

June 13, 2022

Administrator
Elderwood Of Hinckley
710 Spring Lane
Hinckley, MN 55037

RE: Project Number(s) SL23986015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 19, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for 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 - 0250 - 144g.20 Subdivision 1 - Conditions = $3,000
St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000

The total amount you are assessed is $6,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general Free from Maltreatment reconsideration

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

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

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. 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,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23986	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders have been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL23986015-0 On May 17, 2022, through May 19, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were thirty-three (33) residents receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on May 17, 2022, issued for SL23986015-0, tag identification 0110. An immediate correction order was identified on May 18, 2022, issued for SL23986015-0, tag identification 2310.	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 Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This had the potential to affect all of the licensee's 33 residents receiving assisted living with dementia care services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a licensed assisted living director (LALD) to manage and supervise assisted living services for the 33 current residents who received assisted living with dementia care services. On May 17, 2022, at 11:14 a.m., during the entrance interview, owner (O)-B stated he submitted an application for an assisted living director license, however, O-B stated he thought he had a year to complete the process under a "Legacy Three" program and did not yet have his	0 110		

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0 110	Continued From page 2 assisted living director license. Additionally, O-B stated, "we've been doing this for 10 years this way, so, it's kind of a new thing. I think we both did the application", referring to clinical nurse supervisor (CNS)-A. On May 17, 2022, at 12:08 p.m., the surveyor contacted the Minnesota Board of Executives for Long-Term Services and Support (BELTSS). A BELTSS representative conducted a review for verification of O-B's assisted living director licensure. BELTSS confirmed O-B and CNS-A were not listed as having a current LALD license. BELTSS confirmed an application had been submitted by O-B and CNS-A, however, the application had not been completed. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 110		
0 250 SS=I	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the 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	0 250		

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0 250	Continued From page 3 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; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel 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 observation, interview and record review, the licensee failed to show they met the	0 250		

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0 250	Continued From page 4 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. Additionally, the licensee failed to fully cooperate with a survey by the department when the licensee halted correspondence with the department related to immediate correction orders issued on May 17, 2022, and May 18, 2022. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and 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 May 17, 2022, at approximately 11:00 a.m., clinical nurse supervisor (CNS)-A and owner (O)-B 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]:	0 250		

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0 250	Continued From page 5 - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building (s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying 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	0 250		

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0 250	Continued From page 6 protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - 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.	0 250		

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0 250	Continued From page 7 Page five was electronically signed by O-B on May 25, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - 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; - orientation to and implementation of the assisted living bill of rights; - reminders for medications, treatments, or exercises, if provided; - medication and treatment management; and - delegation of tasks by registered nurses or licensed health professionals. On May 19, 2022, at 1:20 p.m., O-B and CNS-A confirmed the licensee provided contracted assisted living services as noted above but failed to develop and implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0110, 0430, 0470, 0550, 0630, 0640, 0680, 0730, 0800, 0810, 0900, 1420, 1470, 1500, 1620, 1650, 1690, 1730, 1750, 1760, 1930, 1940,	0 250		

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0 250	Continued From page 8 1950, 2040, 2110, 2240, 2310 and 3090 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. IMMEDIATE CORRECTION ORDER 0110 On May 17, 2022, at 2:38 p.m., the licensee emailed the survey supervisor a response to immediate correction order tag identification 0110 issued on May 17, 2022, at 1:20 p.m., related to the licensee not employing a licensed assisted living director, as required. The licensee indicated the following, "I am responding to the e-mail regarding my and my wife's assisted living director license application. It is found that our application has a few items that are needed for completion. If we could talk to someone to discuss what those items are, so as to get our assisted living director license application completed." On May 17, 2022, at 3:01 p.m., the survey supervisor emailed the licensee the following, "Please contact the Minnesota Board of Executives for Long Term Services and Supports for information on how to finalize your applications. 335 Randolph Avenue, Suite 210-B St. Paul, MN 55102 O: 651-201-2730 F: 651-797-1376 The department will be unable to lift the immediacy of this correction order until you have either completed your licensure and have provided proof of such or you have contracted with another LALD to oversee your facility in the interim. Please reply all with your immediate plan."	0 250		

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0 250	Continued From page 9 On May 24, 2022, at 8:40 a.m., the survey supervisor again emailed the licensee to inquire about the licensee's immediate plan of correction for tag 0110. The survey supervisor emailed the following, "I am writing to follow-up on this immediate correction order as the department has not yet heard back from you on your immediate plan for correction. The department will be unable to lift the immediacy of this correction order until you have either completed your licensure and have provided proof of such or you have contracted with another LALD to oversee your facility in the interim." No further information was provided. IMMEDIATE CORRECTION ORDER 2310 On May 19, 2022, at 9:27 a.m., the licensee emailed the survey supervisor a response to immediate correction order tag identification 2310 issued on May 18, 2022, at 3:30 p.m., related to bedrails. The licensee indicated the following, "We have received the immediate order for correction, tag identification 2310. We will review the order for correction, and make the necessary corrections by updating all the assessments in the immediate order for correction attachment. We will send proof of the corrections by the end of today." On May 19, 2022, at 8:28 p.m., the licensee emailed the survey supervisor the following, "In the attachment are the necessary Bed Rail Assessments to satisfy the immediate order for correction, tag identification 2310." On May 20, 2022, at 3:31 p.m., the survey supervisor emailed the following to the licensee, "Thank you for the updated assessments. The	0 250		

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0 250	Continued From page 10 department does have a follow-up question related to the assessment for resident, [R7]. In reading the description of the device in place on this resident's bed, it sounds very similar to devices that have been recalled by the Consumer Product Safety Commission, please see link: https://www.cpsc.gov/Newsroom/News-Releases/2021/CPSC-Warns-Consumers-to-Stop-Use-of-Three-Models-of-Adult-Portable-Bed-Rails-Manufactured-by-Bed-Handles-Inc-Due-to-Entrapment-Asphyxia-Hazard Please check the link and confirm back with the department that the resident' s device has not been recalled. If is [sic] has, please provide your plan for next steps." On May 24, 2022, at 8:37 a.m., the survey supervisor again emailed the licensee to inquire about the licensee's immediate plan of correction for tag 2310. The survey supervisor emailed the following, "The department has not received a response from you related to the follow-up question sent on Friday, May 20, 2022. Please confirm whether or not you have reviewed the provided link for potential recall of the device in place on resident [R7] bed." As of June 1, 2022 at 1:54 p.m., no further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted	0 430		

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0 430	Continued From page 11 living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 R1 admitted for service on July 23, 2021, under the comprehensive home care license and began	0 430		

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0 430	Continued From page 12 receiving assisted living services on August 1, 2021. R1's service plan dated July 22, 2019, indicated R1 received services including medication administration and assistance with bathing, grooming, toileting, ambulation, bed mobility, transfers, catheter care and dressing. R1's record lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. R2 R2 admitted for services on April 15, 2016, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's Service Plan, undated, indicated R2 received services for medication management, personal cares, bathing, behavior support, ambulation, toileting, orientation, treatments, pain monitoring, room checks, housekeeping and laundry. R2's record lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted	0 430		

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0 430	Continued From page 13 under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. R3 R3 admitted for services on May 15, 2020, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R3's Service Plan dated May 22, 2020, indicated R3 received services for medication management, fall monitoring, ambulation, daily weight/edema monitoring, behavior monitoring, orientation, glucose checks, bathing, housekeeping and laundry. R3's record lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. On May 18, 2022, at approximately 8:10 a.m., owner (O)-B stated licensee had an older version of the UDALSA and had planned to spend some time to review and update the document prior to providing to residents. O-B confirmed R1, R2, R3, and all other residents receiving services under the licensee's Assisted Living with Dementia Care License had not received the uniform checklist disclosure.	0 430		

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0 430	Continued From page 14 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	0 470		

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0 470	Continued From page 15 Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all 33 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license. The facility was licensed for a capacity of 36 residents and had a current census of 33 residents. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured the facility could respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. During the entrance conference on May 17, 2022, at approximately 10:40 a.m., the surveyor	0 470		

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0 470	Continued From page 16 requested a copy of the facility's staffing plan from licensed clinical nurse supervisor (CNS)-A. On May 17, 2022, at approximately 12:50 p.m., CNS-A provided a copy of the weekly staff schedule dated May 15, 2022, through May 21, 2022, which was posted on a wall near the nurse's desk located in a cubicle style room off the main commons area used by staff. CNS-A stated the schedule could be changed based on the census number of the facility and/or the acuity of the residents. CNS-A confirmed a registered nurse had not developed a written staffing plan to include the above noted required content. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-One (21) days	0 470		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record	0 550		

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0 550	Continued From page 17	0 550		

review, the licensee failed to post in a conspicuous place the required information related to the grievance procedure, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all thirty-three (33) 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:

The licensee lacked a posting of the grievance procedure to include the name, telephone number and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.

On May 17, 2022, at approximately 11:23 a.m., clinical nurse supervisor (CNS)-A verified the main entrance was used by staff, residents and visitors to the facility. The surveyor observed a bulletin board located in the main entrance area lacked the required posting of the grievance procedure.

On May 17, 2022, at approximately 11:36 a.m., CNS-A verified the grievance procedure was not

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0 550	Continued From page 18 posted as required. The licensee's Resident and Care Provider Grievance/Complaint Policy and Procedure, dated June 17, 2011, indicated residents could find the specifics of the grievance complaint process within the Home Care Bill of Rights and complaints would be responded to with a meeting set up by management/owner within 10 days of the grievance/complaint being filed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individual abuse prevention plan with the required content for three of three residents (R1, R3, R2) with records reviewed.	0 630		

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0 630	Continued From page 19 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: R1 R1's diagnoses included progressive supranuclear palsy (neurodegenerative condition that causes problems with balance, vision, speech, movement and swallowing), depression, anxiety and PTSD (mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations). R1's service plan dated July 22, 2019, indicated R1 received services including medication administration and assistance with bathing, grooming, toileting, ambulation, bed mobility, transfers, catheter care and dressing. On May 18, 2022, at approximately 8:48 a.m., the surveyor observed unlicensed personnel (ULP)-D assist R1 to transfer from R1's bed to wheelchair. ULP-D applied a gait belt and instructed R1 to tell ULP-D when she was ready to stand and transfer. R1 leaned heavily to the left side. ULP-D and R1 attempted for R1 to stand, however, R1 but could not and sat back down on the bed, again leaning heavily to the left side. ULP-D	0 630		

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0 630	Continued From page 20 asked R1 if she [R1] wanted to try again. R1 responded "yes." ULP-D and R1 attempted a second time and R1 transferred to the wheelchair with noted difficulty. ULP-D stated, " sometimes she will transfer with assist of one staff, but she has some difficult days that it takes two of us." R1's Vulnerability Assessment dated May 6, 2021, identified areas of vulnerability with chronic pain and disability, inability to manage finances and fall history. Ability to ambulate safely with/without a device was unassessed. R1's individual abuse prevention plan did not include: - the resident's susceptibility to abuse by another individual, including other vulnerable adults; - the resident's risk of abusing other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R3 R3's diagnoses included diabetes mellitus, repeated falls, hypertension and generalized muscle weakness. R3's service plan dated May 22, 2020, indicated R3 received services including medication administration, fall monitoring, ambulation, daily weight/edema monitoring, skin treatment, special diet, bathing, diabetic nail care, orientation, glucose checks, behavior monitoring, room checks, vitals, laundry and housekeeping. On May 18, 2022, at approximately 7:43 a.m., the surveyor observed ULP-C conduct a blood glucose (sugar) test with a result of 118 milligrams per deciliter (mg/dl).	0 630		

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0 630	Continued From page 21 R3's medical record lacked a vulnerability assessment and an individual abuse prevention plan. R2 R2's diagnoses included adult failure to thrive, traumatic brain injury (TBI) and major depressive disorder. R2's service plan, undated, indicated R2 received services including medication administration, dressing, bathing, skin treatments, ambulation, toileting, orientation, wound care, pain monitoring, behavior monitoring, room checks, laundry and housekeeping. On May 19, 2022, at approximately 9:52 a.m., the surveyor observed ULP-E and ULP-C assist R2 transfer from R2's bed to wheelchair. ULP-D applied a gait belt and provided cues to R2 for steps to take for the transfer. R2 required ULP-E, ULP-C and a third ULP was summoned to assist with the transfer due to R2's inability to assist. R2's Vulnerability Assessment dated April 15, 2022, identified areas of vulnerability with chronic conditions pain and disability, inability to manage finances, delusions thoughts to include hallucinations, anxiety and fall history. Additionally, the vulnerability assessment indicated the resident is dependent on staff for all cares and activities of daily living (ADL's) and resident did not always notify anyone of self-neglect situations "if it were to occur." R2's individual abuse prevention plan did not include: - statements of specific measures to be taken to minimize the risk of abuse to that person and	0 630		

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0 630	Continued From page 22 other vulnerable adults. On May 19, 2022, at 11:18 a.m., clinical nurse supervisor (CNS)-A confirmed R1 and R2's Individual Abuse Prevention Plan (IAPP) did not address the above noted areas of risk or include statements of specific measures to be taken to minimize risks. Additionally, CNS-A confirmed R3's record lacked a vulnerability assessment and IAPP. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information to include: (1) posting the 911 emergency number in common areas and near telephones provided by	0 640		

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0 640	Continued From page 23 the assisted living facility; and (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living and the information for reporting suspected maltreatment to MAARC. During a facility tour on May 17, 2022, at approximately 11:30 a.m., with clinical nurse supervisor (CNS)-A, the surveyor observed the common areas lacked the required posting for the 911 emergency number and the reporting number for MAARC. On May 17, 2022, at approximately 11:35 a.m., CNS-A confirmed the 911 emergency number was not posted on or near the telephone located within the main entry area and the contact information or reporting number for MAARC was not posted in a conspicuous manner within the facility.	0 640		

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0 640	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written	0 680		

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0 680	Continued From page 25 emergency preparedness plan with all the required content and post an emergency preparedness plan prominently. This had the potential to affect all thirty-three (33) residents receiving services under the assisted living with dementia 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 potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 17, 2022, at approximately 10:30 a.m., the surveyor requested to review the licensee's emergency preparedness plan. On May 17, 2022, at approximately 3:43 p.m., owner (O)-B provided a 5-page document dated June 9, 2010, titled Emergency Evacuation Procedure. The document provided instructions to staff on what steps were to be taken to remove residents from the building in the event of a fire, how to operate a fire extinguisher, extinguisher locations and the steps to follow in the event of severe weather or a tornado. The licensee's emergency preparedness plan lacked a Hazard Vulnerability Assessment and the following required content: - a description of the population served by the licensee; - process for emergency preparedness (EP)	0 680		

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0 680	Continued From page 26 cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - an evacuation plan customized for the facility; - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies; and - the licensee's role in providing care and treatment at alternative sites. - a communication plan that addressed: - arrangements with other facilities; - names and contact information for staff, resident physicians, and other facilities; - contact information for federal, state, tribal, local EP staff, and ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing resident information and medical documentation; - a means to provide information regarding the facility's needs, and its ability to provide assistance, including occupancy information; and -a method of sharing information from the licensee's emergency plan with residents and their families. - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On May 17, 2022, at approximately 11:23 a.m.,	0 680		

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0 680	Continued From page 27 during a facility tour with clinical nurse supervisor (CNS)-A, the surveyor observed no signage or information posted in the main entrance or elsewhere in the facility regarding the licensee's emergency plan. On May 18, 2022, at approximately 3:55 p.m., O-B confirmed staff were not familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] State Operations Manual which includes the emergency preparedness guidelines). O-B verified the licensee had not developed and implemented the facility's emergency preparedness plan/program as required and stated, "with the new regulations, it's a lot to learn and do. It can be overwhelming." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require	0 730		

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0 730	Continued From page 28 documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure licensee's staff documented the provision of resident services according to the resident's service plans for three of three residents (R3, R1, R2) with	0 730		

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0 730	Continued From page 29 records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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: R3 R3's diagnoses included diabetes mellitus, repeated falls, hypertension and generalized muscle weakness. R3's service plan dated May 22, 2020, indicated R3 received services including medication administration, fall monitoring, ambulation, daily weight/edema monitoring, skin treatment, special diet, bathing, diabetic nail care, orientation, glucose checks, behavior monitoring, room checks, vitals, laundry and housekeeping. On May 18, 2022, at approximately 7:43 a.m., the surveyor observed unlicensed personnel (ULP)-C conduct a blood glucose (sugar) test with a result of 118 milligrams per deciliter (mg/dl). R3's staff task sheet for May 15, 16, 17, 2022, included the following scheduled services: encourage elevation of legs each shift, pain cream, see treatment sheet, encourage incentive spirometer, vitals, dressing, compression stockings (TEDs), toileting, assist of 1, transferring, ambulation, wheeling, bed mobility, meals/snacks, orientation, fall monitoring, behavior monitoring, room checks every 2 hours,	0 730		

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0 730	Continued From page 30 activities, bathing, bowel movements and COVID-19 symptoms. R3's record lacked documentation verifying R3 received the following services May 15, 16 or 17, 2022, during the morning/day shift as scheduled: - 3 of 3 encourage elevation of legs each shift; - 3 of 3 pain cream, see treatment sheet; - 3 of 3 encourage incentive spirometer; and - 3 of 4 room checks every 2 hours. R1 R1's diagnoses included progressive supranuclear palsy (neurodegenerative condition that causes problems with balance, vision, speech, movement and swallowing), depression, anxiety and PTSD (mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations). R1's service plan dated July 22, 2019, indicated R1 received services including medication administration and assistance with bathing, grooming, toileting, ambulation, bed mobility, transfers, catheter care and dressing. On May 18, 2022, at approximately 8:48 a.m., the surveyor observed ULP-D assist R1 transfer from R1's bed to wheelchair. R1's staff task sheet dated May 15, 16, 17, 2022, included the following scheduled services: lotion to arms, legs and back in eve, AFO brace (ankle-foot orthosis, is a brace in an L shape worn on the lower part of the leg or the foot) on in the morning off in the evening, vitals, dressing, transferring, toileting, output in milliliters (mL), bed rails, pain monitoring, behavioral monitoring,	0 730		

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0 730	Continued From page 31	0 730		

fall monitoring, orientation, room checks every 2 hours, meals/snacks, activities, bathing, bowel movements, S/P site cleaning, change day/night bag, clean with vinegar water solution, barrier cream and COVID-19 symptoms.

R1's record lacked documentation verifying R1 received the following services May 15, 16 or 17, 2022, during the morning/day shift as scheduled:
- 3 of 3 AFO brace on in the morning;
- 3 of 4 room checks every 2 hours;
- 3 of 3 vitals;
- 3 of 3 S/P site cleaning; (service description lacked clarification of S/P)
- 3 of 3 change day/night bag - clean with vinegar water solution; and
- 3 of 3 barrier cream three times daily and as needed (PRN);

R2
R2's diagnoses included adult failure to thrive, traumatic brain injury (TBI) and major depressive disorder.

R2's service plan, undated, indicated R2 received services including medication administration, dressing, bathing, skin treatments, ambulation, toileting, orientation, wound care, pain monitoring, behavior monitoring, room checks, laundry and housekeeping.

On May 19, 2022, at approximately 9:52 a.m., the surveyor observed ULP-E and ULP-C assist R2 transfer from R2's bed to wheelchair.

R2's staff task sheet for May 15, 16, 17, 2022, included the following scheduled services: barrier cream, encourage walking (R1 is unable to walk), watch boils on bottom and report if open, nystatin powder to groin, monitor skin back and bottom for

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0 730	Continued From page 32 open areas, warm rice packs to left hip on 20 minutes, off 20 minutes as needed, vitals monthly, dressing, compression stockings (TEDs), grooming, toileting/brief change every 4 hours, transferring, ambulation, wheeling, bed mobility, orientation, pain monitoring, behavior monitoring, fall monitoring, room checks every 2 hours, meals/snacks, activities, bathing, bowel movements and COVID-19 symptoms. R2's record lacked documentation verifying R2 received the following services May 15, 16 or 17, 2022, during the morning/day shift as scheduled: - 3 of 3 barrier cream; - 3 of 3 encourage walking (R2 does not walk); - 3 of 3 watch boils on bottom and report if open; - 3 of 3 nystatin to groin; - 3 of 3 monitor skin back, bottom for open areas; - 3 of 4 room checks every 2 hours; and - 3 of 3 compression stockings (TEDs) on in the morning. On May 18, 2022, at approximately 5:15 p.m., clinical nurse supervisor (CNS)-A confirmed R1, R2 and R3's task sheets did not contain staff signatures that would indicate services had been completed. CNS-A further stated that "some of the services were signed off by staff on the treatment sheet". The surveyor observed treatment sheets provided from CNS-A for R1, R2, R3 and noted the treatment sheets lacked the above noted services or documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		

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0 800	Continued From page 33	0 800		
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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 19, 2022, between 10:20 a.m. and 11:50 a.m., survey staff toured the facility with the owner (O)-B. During the facility tour, survey staff observed the following: 1. The inspection tag on the fire sprinkler system was dated July 2020. 2. Smoke detectors were hanging loose from the ceiling in the mechanical rooms labeled 124 and 127. During the facility tour, the O-B confirmed that the	0 800		

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0 800	Continued From page 34 fire sprinkler system required inspection and that the smoke detectors needed to be repaired. 3. The door and electrical panels for the mechanical room labeled 124 were obstructed by boxes. 4. Cardboard boxes were stacked on the dresser, floor, and table in resident room 1, obstructing these areas. During the facility tour, the O-B confirmed that boxes should not be stored in a manner that creates obstructions. 5. The light fixture was not provided with a cover in resident room 1. During the facility tour, the O-B confirmed that the light fixture required a cover. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	0 810		

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0 810	Continued From page 35 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide the required plans, training, and drills for fire safety and evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 19, 2022, at approximately 11:50 a.m., the clinical nurse supervisor (CNS)-A provided documents for review. Documents were reviewed by survey staff on May 19, 2022, between 11:50 a.m. and 12:30 p.m.	0 810		

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0 810	Continued From page 36 1. The emergency evacuation procedures reference the Pines. The approval and review dates on this document were blank. The CNS-B explained during an interview, at approximately 12:50 p.m., that the Pines was a separate facility at a different location. 2. The fire safety and evacuation plans did not include the identification of unique or unusual resident needs for movement or evacuation. 3. The licensee failed to provide the required fire safety and evacuation training frequency for employees. Additionally, employee training frequency for fire safety and evacuation was not specified within the documentation. A blank staff training certificate was provided for yearly core training. One staff training record dated 04-22-22 was provided for review. 4. The licensee failed to provide annual fire safety and evacuation training for residents. Documentation was requested by survey staff but not provided. 5. The licensee failed to provide the required frequency for evacuation drills. No evacuation drill logs or schedules were included with the documentation. On May 19, 2022, at approximately 12:50 p.m., the CNS-B confirmed during an interview that the facility failed to develop the required content within the fire safety and evacuation plans for the facility location. The CNS-B confirmed that the fire safety and evacuation training frequency for employees and residents was not met and that evacuation drills had not been completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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

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0 900	Continued From page 38 by: Based on observation, interview and record review, the licensee failed to develop and execute a written contract, prior to the start of services, with the required content to provide assisted living services for three of three residents (R1, R3, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included progressive supranuclear palsy (neurodegenerative condition that causes problems with balance, vision, speech, movement and swallowing), depression, anxiety and PTSD (mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations). R1's service plan dated July 22, 2019, indicated R1 received services including medication administration and assistance with bathing, grooming, toileting, ambulation, bed mobility, transfers, catheter care and dressing. On May 18, 2022, at approximately 8:48 a.m., the surveyor observed unlicensed personnel (ULP)-D assisting R1 transfer from R1's bed to wheelchair.	0 900		

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0 900	Continued From page 39 R3 R3's diagnoses included diabetes mellitus, repeated falls, hypertension and generalized muscle weakness. R3's service plan dated May 22, 2020, indicated R3 received services including medication administration, fall monitoring, ambulation, daily weight/edema monitoring, skin treatment, special diet, bathing, diabetic nail care, orientation, glucose checks, behavior monitoring, room checks, vitals, laundry and housekeeping. On May 18, 2022, at approximately 7:43 a.m., the surveyor observed ULP-C conduct a blood glucose (sugar) test with a result of 118 milligrams per deciliter (mg/dl). R2 R2's diagnoses included adult failure to thrive, traumatic brain injury (TBI) and major depressive disorder. R2's service plan, undated, indicated R2 received services including medication administration, dressing, bathing, skin treatments, ambulation, toileting, orientation, wound care, pain monitoring, behavior monitoring, room checks, laundry and housekeeping. On May 19, 2022, at approximately 9:52 a.m., the surveyor observed ULP-E and ULP-C assist R2 transfer from R2's bed to wheelchair. R1, R3 and R2's records lacked a written contract to include all of the terms concerning the provisions of the following as required: (1) housing (2) assisted living services, whether provided	0 900		

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0 900	Continued From page 40 directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. In addition, R1's records lacked evidence that the contract had been fully executed as the facility must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. On May 19, 2022, at approximately 11:50 a.m., owner (O)-B confirmed a written assisted living contract had not been developed or executed for the licensee's thirty-three (33) current residents as required. Additionally, O-B stated he understood the resident agreements the licensee had used "for the last 10 years" to be the contracts required by assisted living regulation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01420 SS=E	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an	01420		

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unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the registered nurse (RN) failed to ensure the unlicensed personnel (ULP) received training in the proper methods to perform the task or procedure for each resident and were able to demonstrate the ability to competently follow the procedure to perform the tasks for two of two (ULP-C, ULP-D) reviewed for the use of a continuous positive airway pressure (CPAP) and Suprapubic catheter belly bag. In addition, the licensee failed to ensure the RN documented instructions for the delegated tasks in the resident's record.

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:

ULP-D
ULP-D's training record lacked documentation of

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01420	Continued From page 42 completed training and competency for a Suprapubic catheter belly bag used by R1. ULP-D was hired on September 23, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On May 18, 2022, at approximately 8:48 a.m., the surveyor observed ULP-D drain R1's suprapubic belly catheter bag with an output measurement of 475 milliliters (mL) and a date written on the belly bag of May 8, 2022. The surveyor asked ULP-D if she had been trained specifically on how to drain, measure and report the results of draining R1's belly bag. ULP-D stated the staff have been trained for catheter cares "and it's just like a leg bag." The surveyor asked how often R1's belly bag is changed, and ULP-D responded, "I don't know, the nurses take care of that." ULP-C ULP-C's training record lacked documentation of completed training and competency for a CPAP used by R2. ULP-C was hired on September 23, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On May 18, 2022, at approximately 9:02 a.m., the surveyor observed ULP-C assist R2 with removal of a CPAP mask and attempt to shut off the machine. ULP-C lacked knowledge of the machine functions. R2 provided verbal instructions to ULP-C on how to shut off the CPAP. The surveyor asked ULP-C if she had been trained on the functions of R2's CPAP and ULP-C stated, "I'm not familiar with this one."	01420		

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01420	Continued From page 43 On March 18, 2022, at approximately 4:35 p.m., clinical nurse supervisor (CNS)-A stated staff were trained and competency tested on cares provided and the tasks staff complete would be listed on the services sheet. CNS-A referred to an untitled task sheet that staff used for all tasks to be completed for R1, R2 and all other residents per shift. CNS-A confirmed the tasks listed lacked specific instructions for the CPAP and suprapubic belly bag. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;	01470		

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01470	Continued From page 44 (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees	01470		

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01470	Continued From page 45	01470		

received orientation to 144G licensing requirements for three of three employees (unlicensed personnel (ULP)-C, ULP-D, ULP-E) with employee records reviewed. This had potential to affect all thirty-three (33) 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, 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 affect a large portion or all the residents).

The findings include:

During the entrance conference on May 17, 2022, at approximately 10:40 a.m., clinical nurse supervisor (CNS)-A and owner (O)-B stated they understood assisted living licensure regulation and requirements.

ULP-C
On May 18, 2022, at 8:06 a.m., the surveyor observed ULP-C provide medication administration to R2.

ULP- C was hired on September 23, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

ULP-C's employee record lacked documentation of the following required orientation:
- an overview of this chapter;
- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff

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01470	Continued From page 46 person; - home care/ assisted living bill of rights; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and - principles of person-centered planning/service delivery. ULP-D On May 18, 2022, at approximately 8:48 a.m., the surveyor observed ULP-D drain R1's suprapubic belly catheter bag. ULP-D was hired on November 3, 2021, to provide direct care to residents. ULP-D's employee record lacked documentation of the following required orientation: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - home care/ assisted living bill of rights; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; - a review of the types of assisted living services the employee will be providing and the facility's	01470		

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category of licensure; and
- principles of person-centered planning/service delivery.

ULP-E
On May 19, 2022, at approximately 9:52 a.m., the surveyor observed ULP-E assist R2 with a transfer from R2's bed to his wheelchair.

ULP-E was hired on May 2, 2022, to provide direct care to residents.

ULP-E's employee record lacked documentation of the following required orientation:
- an overview of this chapter;
- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;
- home care/ assisted living bill of rights;
- consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services;
- a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and
- principles of person-centered planning/service delivery.

On May 18, 2022, at approximately 4:45 p.m., clinical nurse supervisor (CNS)-A confirmed ULP-C, ULP-D and ULP-E did not receive the required assisted living licensure orientation.

No further information was provided.

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01470	Continued From page 48 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct	01500		

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01500	Continued From page 49 support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-D, ULP-E) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01500		

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01500	Continued From page 50 situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D ULP-D had a start date of November 3, 2021. ULP-E ULP-E had a start date of May 2, 2022. ULP-D and ULP-E's employee training records lacked evidence ULP-D and ULP-E successfully completed annual training as required, in the following areas: - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On May 18, 2022, at approximately 4:25 p.m., clinical nurse supervisor (CNS)-A confirmed ULP-D and ULP-E lacked annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	01620		

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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 ensure the registered nurse (RN) completed ongoing resident reassessments and did not exceed 90 days for three of three residents (R3, R1, R2) as required with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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

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01620	Continued From page 52 of the residents). The findings include: R3 R3's service plan dated May 22, 2020, indicated R3 received services including medication administration, fall monitoring, ambulation, daily weight/edema monitoring, skin treatment, special diet, bathing, diabetic nail care, orientation, glucose checks, behavior monitoring, room checks, vitals, laundry and housekeeping. On May 18, 2022, at approximately 7:43 a.m., the surveyor observed unlicensed personnel (ULP)-C conduct a glucose (sugar) test with a result of 118 milligrams per deciliter (mg/dl). R3's record indicated the RN completed a Comprehensive Nursing Assessment on May 15, 2020. R3's record lacked documentation a facility RN conducted a reassessment prior to or not to exceed every 90 days for the resident after May 15, 2020. R1 R1's service plan dated July 22, 2019, indicated R1 received services including medication administration and assistance with bathing, grooming, toileting, ambulation, bed mobility, transfers, catheter care and dressing. On May 18, 2022, at approximately 8:48 a.m., the surveyor observed ULP-D assist R1 transfer from R1's bed to wheelchair. R1's record indicated the RN completed a Comprehensive Nursing Assessment on May 6, 2021. R1's record lacked documentation a facility RN conducted a reassessment prior to or not to	01620		

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01620	Continued From page 53	01620		

exceed every 90 days for the resident after May 6, 2021.

R2
R2's service plan, undated, indicated R2 received services including medication administration, dressing, bathing, skin treatments, ambulation, toileting, orientation, wound care, pain monitoring, behavior monitoring, room checks, laundry and housekeeping.

On May 19, 2022, at approximately 9:52 a.m., the surveyor observed ULP-E and ULP-C assist R2 transfer from R2's bed to wheelchair.

R2's record indicated the RN completed a Comprehensive Nursing Assessment on April 15, 2020, April 20, 2021, and April 15, 2022. R2's record lacked documentation the RN conducted a reassessment prior to or not to exceed every 90 days. R2's record indicated the RN had conducted a comprehensive reassessment annually.

On May 19, 2022, at approximately 12:33 p.m., clinical nurse supervisor (CNS)-A confirmed R3, R1 and R2's ongoing reassessments were not completed at least every 90 days or prior to 90 days using the uniform assessment tool as required. Additionally, CNS-A stated "I looked it up, and I had no idea there were that many requirements with the Assisted Living Facility with Dementia Care (ALFDC) license. I didn't think we had that."

The licensee's Admission of a Resident policy, updated March 2008, indicated a Vulnerability Assessment would be completed within 14 days of admission, a Supervisory Visit would be conducted within 14 days initially by the RN then

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01620	Continued From page 54 rotate with the licensed practical nurse (LPN) every 62 days. Licensee's policy lacked any information pertaining to a 90-day reassessment by the RN. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and	01650		

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01650	Continued From page 55 declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R3, R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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: R3 R3's diagnoses included diabetes mellitus, repeated falls, hypertension and generalized muscle weakness. R3's service plan dated May 22, 2020, indicated R3 received services including medication administration, fall monitoring, ambulation, daily weight/edema monitoring, skin treatment, special diet, bathing, diabetic nail care, orientation, glucose checks, behavior monitoring, room checks, vitals, laundry and housekeeping. On May 18, 2022, at approximately 7:43 a.m., the surveyor observed unlicensed personnel (ULP)-C conduct a glucose (sugar) test with a result of 118 milligrams per deciliter (mg/dl).	01650		

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01650	Continued From page 56 R3's Scheduled Services dated May 15, 2022, included the following completed services signed off by unlicensed personnel and licensed nursing staff: - encourage elevation of legs each shift; - pain cream, see treatment sheet; - encourage incentive spirometer; - vitals; - dressing; - compression stockings (TEDs); - toileting, assist of 1; - transferring; - ambulation; - wheeling; - bed mobility; - meals/snacks; - orientation; - fall monitoring; - behavior monitoring; - room checks every 2 hours; - activities; - bathing; - bowel movements; and - COVID-19 symptoms. R1 R1's diagnoses included progressive supranuclear palsy (neurodegenerative condition that causes problems with balance, vision, speech, movement and swallowing), depression, anxiety and PTSD (mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations). R1's service plan dated July 22, 2019, indicated R1 received services including medication administration and assistance with bathing, grooming, toileting, ambulation, bed mobility,	01650		

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01650	Continued From page 57 transfers, catheter care and dressing. On May 18, 2022, at approximately 8:48 a.m., the surveyor observed ULP-D assist R1 transfer from R1's bed to wheelchair. R1's Scheduled Services dated May 15, 2022, included the following completed services signed off by unlicensed personnel and licensed nursing staff: - lotion to arms, legs and back in eve [evening]; - AFO brace on in the morning off in the evening; - vitals; - dressing; - transferring; - toileting, output in milliliters (mL); - bed rails; - pain monitoring; - behavioral monitoring; - fall monitoring; - orientation; - room checks every 2 hours; - meals/snacks; - activities; - bathing; - bowel movements; - S/P site cleaning; - change day/night bag, clean with vinegar water solution; - barrier cream; and - COVID-19 symptoms. R2 R2's diagnoses included adult failure to thrive, traumatic brain injury (TBI) and major depressive disorder. R2's service plan, undated, indicated R2 received services including medication administration, dressing, bathing, skin treatments, ambulation,	01650		

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01650	Continued From page 58 toileting, orientation, wound care, pain monitoring, behavior monitoring, room checks, laundry and housekeeping. On May 19, 2022, at approximately 9:52 a.m., the surveyor observed ULP-E and ULP-C assist R2 transfer from R2's bed to wheelchair. R2's Scheduled Services dated May 15, 2022, included the following completed services signed off by unlicensed personnel and licensed nursing staff: - barrier cream; - encourage walking; - watch boils on bottom and report if open; - nystatin powder to groin; - monitor skin back and bottom for open areas; - warm rice packs to left hip on 20 minutes, off 20 minutes as needed; - vitals monthly; - dressing; - compression stockings (TEDs); - grooming; - toileting/brief change every 4 hours; - transferring; - ambulation; - wheeling; - bed mobility; - orientation; - pain monitoring; - behavior monitoring; - fall monitoring; - room checks every 2 hours; - meals/snacks; - activities; - bathing; - bowel movements; and - COVID-19 symptoms. R3, R1 and R2's service plan lacked the following	01650		

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01650	Continued From page 59 required content: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided. On May 19, 2022, at approximately 10:53 a.m., clinical nurse supervisor (CNS)-A confirmed the service plan did not include all required content. Additionally, CNS-A stated all resident service plans were a template form used by the licensee for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving	01690		

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01690	Continued From page 60 medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain current medication management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	01690		

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01690	Continued From page 61 During the entrance conference on May 17, 2022, at 11:10 a.m., clinical nurse supervisor (CNS)-A confirmed the licensee provided medication management services to the licensee's residents. The licensee lacked the following required policies: - preparing and giving medications; - verifying that prescription drugs are administered as prescribed; - documenting medication management activities; and - monitoring and evaluating medication use. On May 19, 2022, at 12:40 p.m., CNS-A confirmed the licensee lacked the above noted policies. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01690		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of	01730		

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01730	Continued From page 62 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 develop and maintain a current individualized medication management record for each resident to include all required content for three of three residents (R3, R2, R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01730		

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01730	Continued From page 63	01730		

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 May 17, 2022, at approximately 11:05 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services for the licensee's residents.

R3
R3's diagnoses included diabetes mellitus, repeated falls, hypertension and generalized muscle weakness.

R3's service plan dated May 22, 2020, indicated R3 received services including medication administration.

R3's medication administration record (MAR) dated May 2022, included the following medications: one mild pain reliever, one diuretic, one thyroid supplement, one blood pressure reducer, one sleep aide, one blood thinner, one stool softener and one stomach acid reducer.

On May 18, 2022, at approximately 8:09 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R3's morning medications.

R2
R2's diagnoses included adult failure to thrive, traumatic brain injury (TBI) and major depressive disorder.

R2's service plan, undated, indicated R2 received

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01730	Continued From page 64 services including medication administration. R2's MAR dated May 2022, included the following medications: one mild pain reliever, two muscle spasm medications, one cholesterol reducer, one allergy medication, one eye drop, one inhaler, one antibiotic, one seizure medication, one stool softener, two antidepressants, one nerve pain reducer, one diuretic, one thyroid supplement, two mucus reducers, one sleep aide, one stomach acid reducer, one anti-constipation and two vitamin supplements. On May 18, 2022, at approximately 9:02 a.m., the surveyor observed ULP-C administer R2's morning medications. R1 R1's diagnoses included progressive supranuclear palsy (neurodegenerative condition that causes problems with balance, vision, speech, movement and swallowing), depression, anxiety and PTSD (mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations). R1's service plan dated July 22, 2019, indicated R1 received services including medication administration. R1's MAR dated May 2022, included the following medications: one mild pain relievers, one seizure medication, one antipsychotic, one blood pressure reducer, one sleep aide, one bladder medication, two stomach acid reducers, one anxiety medication, one narcotic pain medication, one nebulizer solution inhaler and one stool softener.	01730		

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01730	Continued From page 65 On May 18, 2022, at approximately 9:11 a.m., the surveyor observed ULP-C administer R1's morning medication. R3, R2 and R1's individualized medication management plan lacked the following: - a statement describing the medication management services that will be provided; - documentation of specific resident instructions relating to the administration of medications; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; - any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; and - completion of medication reconciliation. On May 19, 2022, at approximately 11:18 a.m., clinical nurse supervisor (CNS)-A confirmed R3, R2 and R1's individualized medication management plans did not include all the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration	01750		

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01750	Continued From page 66 When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse documented resident-specific instructions for their medications for one of three residents (R1) whose medication administration was delegated to unlicensed personnel. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1's medication administration record (MAR) lacked specific, written instructions regarding the administration of scheduled medications. R1's diagnoses included progressive	01750		

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01750	Continued From page 67	01750		

supranuclear palsy (neurodegenerative condition that causes problems with balance, vision, speech, movement and swallowing), depression, anxiety and PTSD (mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations).

R1's service plan dated July 22, 2019, indicated R1 received services including medication administration.

On May 18, 2022, at approximately 9:11 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's morning medications. ULP-C opened the med caddie (a multicompartment pill storage container) labeled Wednesday morning, poured the medications into a paper medication cup and counted the number of pills. ULP-C confirmed 12 pills were in the medication cup and dotted all 12 morning medications in the MAR. ULP-C separated two (2) gabapentin capsules from the pill cup, placed all other pills into a clear baggie and crushed the bagged pills. The crushed pills were put back into the medication cup and ULP-C opened the gabapentin capsules and added the gabapentin powder into the crushed medications. The medications were then added to three (3) spoonful's of chocolate pudding and mixed. The surveyor asked where ULP-C read the instructions to crush all meds and add the medications to pudding and if ULP-C was aware that two of R1's medications specifically indicated "do not crush or chew" on the MAR. ULP-C stated, "we just know, I've been doing this along time. I just know, I've been on meds awhile." ULP-C administered the medications mixed into pudding to R1 and returned to the MAR to initial medications as

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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
01750	Continued From page 68 administered. R1's Medication Administration Record, dated May 2022, included: - acetaminophen 500 milligrams (mg) three times daily; - carbamazepine 100 mg three times daily; - escitalopram 20 mg one tablet every morning; - gabapentin 400 mg three times daily - swallow whole, do not crush or chew; - lisinopril 30 mg one tab daily; - loperamide capsule 2 mg one time daily; - magnesium 64 mg two tablets daily - swallow whole, do not crush or chew; - melatonin 10 mg one tablet one time daily; - metoclopramide 10 mg three times daily; - oxybutynin 5 mg 2 tablets one time daily; - hydromorphone 2 mg two times daily; and - lorazepam 1 mg one time daily. The licensee failed to provide resident-specific instructions pertaining to crushed medications and mixing the medications into food. Additionally, The MAR lacked pill identifiers for staff to verify the medication. On May 18, 2022, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-A confirmed there were no specific instructions for R1's crushed medications or pill identifiers on the MAR. CNS-A stated, "she [ULP-C] has worked here a long time and knows how to do it and knows the resident's preference." The licensee's General Policies in Administering Medications, dated March 10, 2020, did not address specific written instructions for medication administration by ULP's. No further information was provided.	01750		

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01750	Continued From page 69 TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff administered medications as ordered for one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01760		

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01760	Continued From page 70 The findings include: R1's diagnoses included progressive supranuclear palsy (neurodegenerative condition that causes problems with balance, vision, speech, movement and swallowing), depression, anxiety and PTSD (mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations). R1's service plan dated July 22, 2019, indicated R1 received services including medication administration. On May 18, 2022, at approximately 9:11 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's morning medications. ULP-C opened the med caddie (a multicompartment pill storage container) labeled Wednesday morning, poured the medications into a paper medication cup and counted the number of pills. ULP-C confirmed 12 pills were in the medication cup and dotted all 12 medications in the medication administration record (MAR). All medications listed on the MAR for R1 lacked pill identifiers for verification. ULP-C separated two (2) gabapentin capsules from the pill cup, placed all other pills that included magnesium 64 mg (do not crush or chew) into a clear baggie and crushed the bagged pills. The crushed pills were poured back into a medication cup and ULP-C opened the two gabapentin capsules and poured the gabapentin powder into the crushed medications. The medications were then added to three (3) spoonful's of chocolate pudding and mixed. The surveyor asked where ULP-C read the instructions to crush all meds and add the medications to pudding and if ULP-C was aware	01760		

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that two of R1's medications specifically indicated "do not crush or chew" on the MAR. ULP-C stated, "we just know, I've been doing this along time. I just know, I've been on meds awhile."

R1's prescriber orders dated May 13, 2022, included a routine standing order that indicated meds may be crushed unless the dosage form cannot be crushed. Gabapentin and Magnesium indicated "do not crush or chew" on the MAR.

R1's Medication Administration Record, dated May 2022, included:
- acetaminophen 500 milligrams (mg) three times daily;
- carbamazepine 100 mg three times daily;
- escitalopram 20 mg one tablet every morning;
- gabapentin 400 mg three times daily - swallow whole, do not crush or chew;
- lisinopril 30 mg one tab daily;
- loperamide capsule 2 mg one time daily;
- magnesium 64 mg two tablets daily - swallow whole, do not crush or chew;
- melatonin 10 mg one tablet one time daily;
- metoclopramide 10 mg three times daily;
- oxybutynin 5 mg 2 tablets one time daily;
- hydromorphone 2 mg two times daily; and
- lorazepam 1 mg one time daily.

On May 18, 2022, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-A confirmed all of R1's medications were crushed and/or capsules opened and mixed with food by ULP-C, including the gabapentin and magnesium, even though the MAR indicated the two medications were not to be crushed or chewed. CNS-A stated all MARs were provided by the pharmacy and the pharmacy was unable to add specific instructions.

No further information was provided.

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01760	Continued From page 72 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01930		

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01930	Continued From page 73 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 May 17, 2022, at approximately 11:00 a.m., clinical nurse supervisor (CNS)-A and owner (O)-B confirmed the licensee provided treatment and therapy services to residents as prescribed. On May 18, 2022, at approximately 7:20 a.m., the licensee's assisted living licensing policies and procedures were requested from O-B. The policies and procedures provided did not include treatment and therapy policies to address the following: - providing the treatment or therapy; - documenting treatment or therapy activities; - educating and communicating with residents about treatments or therapies they are receiving; - monitoring and evaluating the treatment or therapy; and - communicating with the prescriber. On May 19, 2022, at approximately 12:30 p.m., CNS-A confirmed the above noted treatment and therapy management services policies and procedures had not been developed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01930		

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01940	Continued From page 74	01940		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop individual treatment management plans with all required content for three of three residents (R3, R2, R1)	01940		

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01940	Continued From page 75 who received ordered treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 17, 2022, at approximately 11:00 a.m., clinical nurse supervisor (CNS)-A confirmed the licensee provided treatment and therapy services to residents. R3 R3's diagnoses included diabetes mellitus, repeated falls, hypertension and generalized muscle weakness. R3's service plan dated May 22, 2020, indicated R3 received services including glucose (sugar) checks and compression stockings (TEDs). On May 18, 2022, at approximately 7:43 a.m., the surveyor observed unlicensed personnel (ULP)-C conduct a glucose test with a result of 118 milligrams per deciliter (mg/dl). R2 R2's diagnoses included adult failure to thrive, traumatic brain injury (TBI) and major depressive disorder. R2's service plan, undated, indicated R2 received services including nebulizer treatments, warm	01940		

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01940	Continued From page 76 rice packs, wound care, TEDs and continuous positive airway pressure (CPAP). On May 18, 2022, at approximately 8:06 a.m., the surveyor observed ULP-E assist R2 with removal of a CPAP mask and assist with an adjustment of a left arm sling worn by R2. R1 R1's diagnoses included progressive supranuclear palsy (neurodegenerative condition that causes problems with balance, vision, speech, movement and swallowing), depression, anxiety and PTSD (mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations). R1's service plan dated July 22, 2019, indicated R1 received services including suprapubic catheter care, oxygen and AFO (ankle foot orthotic device to assist with instability of the limb) brace monitoring twice daily. On May 18, 2022, at approximately 8:48 a.m., the surveyor observed ULP-D drain R1's suprapubic catheter with results of 475 milliliters (mL). R3, R2, R1's record lacked an Individualized Treatment and Therapy plan to include the following: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatment or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or	01940		

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01940	Continued From page 77 appropriate licensed health professional when a problem arises with the treatments or therapy services; and - any resident-specific requirements related to documentation of treatment and therapy was received, verification all treatment and therapy was administered as prescribed, and monitoring occurred to prevent possible complications or adverse reactions. On May 18, 2022, at approximately 4:30 p.m., CNS-A confirmed R1, R2 and R3 lacked Individualized Treatment and Therapy Plans. The licensee's Treatment/Medication Policy, dated April 2020, indicated all treatments would be recorded on a treatment record and would be monitored by licensed staff daily for compliance and effectiveness. The policy did not address the requirement for an individualized treatment and therapy plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed	01950		

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01950	Continued From page 78 personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: R3 R3's diagnoses included diabetes mellitus, repeated falls, hypertension and generalized muscle weakness.	01950		

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01950	Continued From page 79 R3's service plan dated May 22, 2020, indicated R3 received services including glucose (sugar) checks and compression stockings (TEDs). On May 18, 2022, at approximately 7:43 a.m., the surveyor observed unlicensed personnel (ULP)-C conduct a glucose test with a result of 118 milligrams per deciliter (mg/dl). R2 R2's diagnoses included adult failure to thrive, traumatic brain injury (TBI) and major depressive disorder. R2's service plan, undated, indicated R2 received services including nebulizer treatments, warm rice packs, wound care, TEDs and continuous positive airway pressure (CPAP). On May 18, 2022, at approximately 8:06 a.m., the surveyor observed ULP-E assist R2 with removal of a CPAP mask and assist with an adjustment of a left arm sling worn by R2. R1 R1's diagnoses included progressive supranuclear palsy (neurodegenerative condition that causes problems with balance, vision, speech, movement and swallowing), depression, anxiety and PTSD (mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations). R1's service plan dated July 22, 2019, indicated R1 received services including suprapubic catheter care, oxygen and AFO (ankle foot orthotic device to assist with stability of the limb) brace monitoring twice daily.	01950		

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01950	Continued From page 80 On May 18, 2022, at approximately 8:48 a.m., the surveyor observed ULP-D drain R1's suprapubic catheter with results of 475 milliliters (mL). On May 19, 2022, at approximately 12: 50 p.m., clinical nurse supervisor (CNS)-A provided a document to the surveyor titled Treatment Record/Medication Administration Record with the format of a medication administration record (MAR). CNS-A confirmed R3, R2 and R1 lacked a treatment record indicating what the treatment needs were of individual residents, and any specific instructions that would instruct staff how to complete and document the treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by:	02040		

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02040	Continued From page 81 Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. Hazards were not assessed and mitigated to protect residents from harm. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 19, 2022, at approximately 11:50 a.m., the clinical nurse supervisor (CNS)-A provided documents for review. Documents were reviewed by survey staff on May 19, 2022, between 11:50 a.m. and 12:30 p.m. A hazard vulnerability assessment was not provided that included hazards or safety risks identified on and around the property. Hazards were not assessed and mitigated to protect residents from harm. On May 19, 2022, at approximately 12:50 p.m., the CNS-A confirmed during an interview that the facility failed to complete a hazard vulnerability or safety risk assessment on and around the property. They also confirmed that property hazards had not been assessed and mitigated to protect residents from harm. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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

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02110	Continued From page 83 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed and/or implemented. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 36 residents. On May 18, 2022, at 4:20 p.m., clinical nurse supervisor (CNS)-A confirmed the inclusive list of dementia care policies and procedures had not been developed, implemented or provided to each resident and/or representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the	02240		

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02240	Continued From page 84 resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why	02240		

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02240	Continued From page 85	02240		

an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the residents and a written acknowledgement received for three of three residents (R1, R2, R3) with records reviewed.

This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021, with a bed capacity of 36 residents.

R1
R1's diagnoses included progressive supranuclear palsy (neurodegenerative condition that causes problems with balance, vision, speech, movement and swallowing), depression, anxiety and PTSD (mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations).

R1's record included an acknowledgement dated

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02240	Continued From page 86 July 23, 2012, that the resident had received the Minnesota Home Care Bill of Rights, Patient Rights. R2 R2's diagnoses included adult failure to thrive, traumatic brain injury (TBI) and major depressive disorder. R2's record included an acknowledgement dated April 20, 2016, that the resident had received the Minnesota Home Care Bill of Rights, Patient Rights. R3 R3's diagnoses included diabetes mellitus, repeated falls, hypertension and generalized muscle weakness. R3's record included an acknowledgement dated May 14, 2020, that the resident had received the Minnesota Home Care Bill of Rights, Patient Rights. On May 18, 2022, at 4:55 p.m., owner (O)-B stated he thought the Minnesota Bill of Rights for Assisted Living Residents, Patient Rights that had been signed by R1, R2 and R3 were the current and accurate Minnesota Bill of Rights for Assisted Living Residents. O-B stated he was unaware of changes made to the Minnesota Bill of Rights for Assisted Living Residents since 2012, 2016 or 2020. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		

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02310	Continued From page 87	02310		
02310 SS=I	144G.91 Subd. 4 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 twelve of thirteen residents (R1, R2, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13) with siderails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 On May 18, 2022, at approximately 9:05 a.m., the surveyor observed clinical nurse supervisor (CNS)-A measure R1's left upper siderail, which was affixed to the bed. The siderail was metal, had six vertical bars with five openings in the center and two bars horizontal away from the center bars with three openings each. The openings between the bars for zone 1 varied, with the largest opening measuring 2 1/2 inches. The measurements between the mattress and the	02310		

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02310	Continued From page 88	02310		

bedrail for zone 3, measured 0 inches. The measurements between the top of the rail to the head of bed for zone 6, measured three inches, and the measurements between the headboard and the end of the mattress for zone 7, measured 3.5 inches.

R1's diagnosis included progressive supranuclear palsy.

R1's Service Plan dated July 22, 2019, indicated R1's services included medication administration, behavior monitoring, room checks, transferring, ambulation, dressing, grooming, toileting, bed mobility, catheter cares, bathing, laundry and housekeeping.

R1's medical record included education of the risks and benefits associated with the use of siderails, signed by CNS-A on February 2, 2022.

R1's medical record included a Care Plan, dated July 15, 2021, which indicated R1's right siderail was to be used at all times, slid under the mattress and was to aide R1 with bed mobility. CNS-A indicated the siderail assessment dated February 2, 2022, had been reviewed with R1 and family, and indicated a copy of the Food and Drug Administration (FDA's) "A Guide to Bed Safety," had been provided to R1; however, R1's record lacked documentation of a siderail assessment to include measurements.

R2
On May 18, 2022, at approximately 9:10 a.m., the surveyor observed CNS-A measure R2's bilateral upper siderails, which were affixed to the bed. The siderail was metal, had eight vertical bars with nine openings. The openings between the bars for zone 1 varied, with the largest opening

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02310	Continued From page 89	02310		

measuring 3 1/2 inches. The measurements between the mattress and the bedrail for zone 3, measured 0 inches. The measurements between the top of the rail to the head of bed for zone 6, measured three inches, and the measurements between the headboard and the end of the mattress for zone 7, measured 2.5 inches.

R2's diagnosis included traumatic brain injury (TBI).

R2's Service Plan, undated, indicated R2's services included medication administration, behavior monitoring, pain monitoring, room checks, transferring, ambulation, dressing, grooming, toileting, wound care, bathing, laundry and housekeeping.

R2's medical record included education of the risks and benefits associated with the use of siderails, signed by CNS-A on February 2, 2022.

R2's medical record included a Care Plan, dated October 20, 2020, that did not indicate siderails were to be used. CNS-A indicated the siderail assessment dated February 2, 2022, had been reviewed with R2 and family, and indicated a copy of the FDA's "A Guide to Bed Safety," had been provided to R2; however, R2's record lacked documentation of a siderail assessment to include measurements.

R4
On May 18, 2022, at approximately 9:15 a.m., the surveyor observed CNS-A measure R4's left lower siderail, which was secured to the bed with straps that wrap around the box spring. The siderail was black metal, had two horizontal bars and three openings. The openings between the bars for zone 1 measured the largest opening 4

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02310	Continued From page 90 1/4 inches. The measurements between the mattress and the bedrail for zone 3, measured 0 inches. The measurements between the top of the rail to the head of bed for zone 6, measured thirty-two inches. R4's diagnosis included cognitive disorder. R4's Service Plan dated February 16, 2021, indicated R4's services included medication administration, safety rail for hand hold to get in/out of bed, room checks, bathing, laundry and housekeeping. R4's medical record included education of the risks and benefits associated with the use of siderails, signed by CNS-A on February 2, 2022. R4's medical record included a Care Plan, undated, and indicated R4's left siderail was to be used at all times. CNS-A indicated the siderail assessment dated February 2, 2022, had been reviewed with R4 and family, and indicated a copy of the FDA's "A Guide to Bed Safety," had been provided to R4; however, R4's record lacked documentation of a siderail assessment to include measurements. R5 On May 18, 2022, at approximately 9:20 a.m., the surveyor observed CNS-A measure R5's bilateral upper siderails, which were affixed to the bed. The siderail was metal and had eight vertical bars with nine openings. The openings between the bars for zone 1 varied, with the largest opening measuring 3 1/2 inches. The measurements between the mattress and the bedrail for zone 3, measured 0 inches. The measurements between the top of the rail to the head of bed for zone 6, measured three inches, and the measurements	02310		

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02310	Continued From page 91 between the headboard and the end of the mattress for zone 7, measured 2.5 inches. R5's diagnosis included chronic kidney disease (CKD). R5's Service Plan dated July 2, 2021, indicated R5's services included medication administration, accu checks, dressing, grooming, catheter cares, support stockings (TEDs), toileting, transferring, behavior monitoring, fall monitoring, room checks, bed rails/hand hold to get in/out of bed, bathing, laundry and housekeeping. R5's medical record included education of the risks and benefits associated with the use of siderails, signed by CNS-A on February 2, 2022. R5's medical record included a Care Plan, undated, and indicated R5's bilateral siderails was to be used throughout the day. CNS-A indicated the siderail assessment dated February 2, 2022, had been reviewed with R5 and family, and indicated a copy of the FDA's "A Guide to Bed Safety," had been provided to R5; however, R5's record lacked documentation of a siderail assessment to include measurements. R6 On May 18, 2022, at approximately 9:25 a.m., the surveyor observed CNS-A measure R6's bilateral upper siderails, which were affixed to the bed. The siderail was metal and had eight vertical bars with nine openings. The openings between the bars for zone 1 varied, with the largest opening measuring 3 1/2 inches. The measurements between the mattress and the bedrail for zone 3, measured 0 inches. The measurements between the top of the rail to the head of bed for zone 6, measured three inches, and the measurements	02310		

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02310	Continued From page 92 between the headboard and the end of the mattress for zone 7, measured 2.5 inches. R6's diagnosis included Parkinson's disease. R6's Service Plan undated, indicated R6's services included medication administration, dressing, grooming, toileting, transferring, behavior monitoring, room checks, positioning/bed mobility, safety rails/bed mobility, bathing, laundry and housekeeping. R6's medical record included education of the risks and benefits associated with the use of siderails, signed by CNS-A on January 1, 2022. R6's medical record included a Care Plan, undated, did not indicate R6 had bilateral siderails. CNS-A indicated the siderail assessment dated January 1, 2022, had been reviewed with R6 and family, and indicated a copy of the FDA's "A Guide to Bed Safety," had been provided to R6; however, R6's record lacked documentation of a siderail assessment to include measurements. R7 On May 18, 2022, at approximately 9:30 a.m., the surveyor observed CNS-A measure R7's upside-down U-shaped bed rail, which was secured to the bed with straps that wrap around the box spring. The siderail was black metal, had a single curved top and measured 26 inches tall and 11.5 inches across the opening. The measurements between the mattress and the bedrail for zone 3, measured 0 inches. The measurements between the top of the rail to the head of bed for zone 6, measured eighteen inches.	02310		

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02310	Continued From page 93 R7's diagnosis included Parkinson's disease. R7's Service Plan undated, indicated R7's services included medication administration, dressing, grooming, bed mobility, toileting, ambulation, fall monitoring, room checks, bathing, laundry and housekeeping. R7's medical record included education of the risks and benefits associated with the use of siderails, signed by CNS-A on February 8, 2022. R7's medical record included a Care Plan, undated, and indicated R7's siderail was to be used while in bed and safety rails in place to provide a hand/hold to get out of bed and bed mobility. CNS-A indicated the siderail assessment dated February 8, 2022, had been reviewed with R7 and family, and indicated a copy of the FDA's "A Guide to Bed Safety," had been provided to R4; however, R4's record lacked documentation of a siderail assessment to include measurements. R8 On May 18, 2022, at approximately 9:35 a.m., the surveyor observed CNS-A measure R8's bilateral upper siderails, which were affixed to the bed. The siderails were metal, had six vertical bars with five openings in the center and two bars horizontal away from the center bars with three openings each. The openings between the bars for zone 1 varied, with the largest opening measuring 2 1/2 inches. The measurements between the mattress and the bedrail for zone 3, measured 0 inches. The measurements between the top of the rail to the head of bed for zone 6, measured three inches, and the measurements between the headboard and the end of the mattress for zone 7, measured 3.5 inches.	02310		

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02310	Continued From page 94 R8's diagnosis included multiple sclerosis (MS). R8's Service Plan undated, indicated R8's services included medication administration, behavior monitoring, room checks, transferring, dressing, grooming, toileting, pain monitoring, vitals/weights, bathing, laundry and housekeeping. R8's medical record included education of the risks and benefits associated with the use of siderails, signed by CNS-A February 2, 2022. R8's medical record included a Care Plan, undated, indicated R8's siderails were to be used while up in bed. CNS-A indicated the siderail assessment dated February 2, 2022, had been reviewed with R8 and family, and indicated a copy of the FDA's "A Guide to Bed Safety," had been provided to R8; however, R8's record lacked documentation of a siderail assessment to include measurements. R9 On May 18, 2022, at approximately 9:40 a.m., the surveyor observed CNS-A measure R9's bilateral upper siderails, which were affixed to the bed. The siderails were metal, had six vertical bars with five openings in the center and two bars horizontal away from the center bars with three openings each. The openings between the bars for zone 1 varied, with the largest opening measuring 2 1/2 inches. The measurements between the mattress and the bedrail for zone 3, measured 0 inches. The measurements between the top of the rail to the head of bed for zone 6, measured three inches, and the measurements between the headboard and the end of the mattress for zone 7, measured 3.5 inches.	02310		

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	23986	A. BUILDING: _____ B. WING _____	05/19/2022

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ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

(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
02310	Continued From page 95 R9's diagnosis included rhabdomyolosis. R9's Service Plan undated, indicated R9's services included medication administration, behavior monitoring, bed mobility, room checks, transferring, dressing, grooming, toileting, pain monitoring, bed rails, vitals/weights, bathing, laundry and housekeeping. R9's medical record included education of the risks and benefits associated with the use of siderails, signed by CNS-A March 2, 2022. R9's medical record included a Care Plan, undated, indicated R9's siderails were to be used at all times while up in bed and right sided siderail to aid in repositioning/handhold to get in/out of bed. CNS-A indicated the siderail assessment dated March 2, 2022, had been reviewed with R9 and family, and indicated a copy of the FDA's "A Guide to Bed Safety," had been provided to R9; however, R9's record lacked documentation of a siderail assessment to include measurements. R10 On May 18, 2022, at approximately 9:45 a.m., the surveyor observed CNS-A measure R10's bilateral upper siderails, which were affixed to the bed. The siderails were metal, had six vertical bars with five openings in the center and two bars horizontal away from the center bars with three openings each. The openings between the bars for zone 1 varied, with the largest opening measuring 2 1/2 inches. The measurements between the mattress and the bedrail for zone 3, measured 0 inches. The measurements between the top of the rail to the head of bed for zone 6, measured three inches, and the measurements between the headboard and the end of the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23986	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

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02310	Continued From page 96 mattress for zone 7, measured 3.5 inches. R10's diagnosis included coronary artery disease (CAD). R10's Service Plan undated, indicated R10's services included medication administration, orientation, behavior monitoring, room checks, transferring, safety rails/trapeze bar, dressing, grooming, toileting, pain monitoring, vitals/weights, bathing, laundry and housekeeping. R10's medical record included education of the risks and benefits associated with the use of siderails, signed by CNS-A December 8, 2021. R10's medical record included a Care Plan, undated, indicated R10's siderails were to be used while in bed, safety rails in place for a hand hold to get in/out of bed and bed mobility-trapeze bar in place to be able to get herself up in bed and positioned. CNS-A indicated the siderail assessment dated December 8, 2021, had been reviewed with R10 and family, and indicated a copy of the FDA's "A Guide to Bed Safety," had been provided to R10; however, R10's record lacked documentation of a siderail assessment to include measurements. R11 On May 18, 2022, at approximately 9:50 a.m., the surveyor observed CNS-A measure R11's bilateral upper siderails, which were affixed to the bed. The siderails were metal, had six vertical bars with five openings in the center and two bars horizontal away from the center bars with three openings each. The openings between the bars for zone 1 varied, with the largest opening measuring 2 1/2 inches. The measurements	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23986	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

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02310	Continued From page 97	02310		

between the mattress and the bedrail for zone 3, measured 0 inches. The measurements between the top of the rail to the head of bed for zone 6, measured three inches, and the measurements between the headboard and the end of the mattress for zone 7, measured 3.5 inches.

R11's diagnosis included sepsis.

R11's Service Plan undated, indicated R11's services included medication administration, orientation, behavior monitoring, room checks, transferring, dressing, grooming, toileting, pain monitoring, vitals/weights, bathing, laundry and housekeeping.

R11's medical record included education of the risks and benefits associated with the use of siderails, signed by CNS-A January 1, 2022.

R11's medical record included a Care Plan, undated, indicated R10's siderails were to be used while in bed, safety rails in place for a hand hold to get in/out of bed and bed mobility-trapeze bar in place to be able to get herself up in bed and positioned. CNS-A indicated the siderail assessment dated January 1, 2022, had been reviewed with R11 and family, and indicated a copy of the FDA's "A Guide to Bed Safety," had been provided to R11; however, R11's record lacked documentation of a siderail assessment to include measurements.

R12
On May 18, 2022, at approximately 9:55 a.m., the surveyor observed CNS-A measure R12's bilateral upper siderails, which were affixed to the bed. The siderails were metal, had six vertical bars with five openings in the center and two bars horizontal away from the center bars with three

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	23986	A. BUILDING: _____ B. WING _____	05/19/2022

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ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

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02310	Continued From page 98	02310		

openings each. The openings between the bars for zone 1 varied, with the largest opening measuring 2 1/2 inches. The measurements between the mattress and the bedrail for zone 3, measured 0 inches. The measurements between the top of the rail to the head of bed for zone 6, measured three inches, and the measurements between the headboard and the end of the mattress for zone 7, measured 3.5 inches.

R12's diagnosis included pulmonary vascular disease (PVD).

R12's Service Plan undated, indicated R12's services included medication administration, behavior monitoring, room checks, orientation, skin treatment, transferring, vitals/weights, bathing, laundry and housekeeping.

R12's medical record included education of the risks and benefits associated with the use of siderails, signed by CNS-A August 9, 2021.

R12's medical record included a Care Plan, undated, indicated R12's siderails were to be used while in bed, safety rails in place for a hand hold to get in/out of bed. CNS-A indicated the bed rail assessment dated August 9, 2021, had been reviewed with R12 and family, and indicated a copy of the FDA's "A Guide to Bed Safety," had been provided to R12; however, R12's record lacked documentation of a siderail assessment to include measurements.

R13
On May 18, 2022, at approximately 10:00 a.m., the surveyor observed CNS-A measure R13's bilateral upper siderails, which were affixed to the bed. The siderails were metal, had six vertical bars with five openings in the center and two bars

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	23986	A. BUILDING: _____ B. WING _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

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02310	Continued From page 99	02310		

horizontal away from the center bars with three openings each. The openings between the bars for zone 1 varied, with the largest opening measuring 2 1/2 inches. The measurements between the mattress and the bedrail for zone 3, measured 0 inches. The measurements between the top of the rail to the head of bed for zone 6, measured three inches, and the measurements between the headboard and the end of the mattress for zone 7, measured 3.5 inches.

R13's diagnosis included pulmonary vascular disease (PVD).

R13's Service Plan undated, indicated R12's services included medication administration, dressing, wound care/heel floats, behavior monitoring, pain management, room checks, orientation, fall monitoring, vitals/weights, bathing, laundry and housekeeping.

R13's medical record included education of the risks and benefits associated with the use of siderails, signed by CNS-A, however the bedrail assessment was undated.

R13's medical record included a Care Plan, undated, indicated R13's siderails were to be used while in bed, safety rails in place to use as a hand hold to assist with bed mobility. CNS-A indicated the siderail assessment. undated, had been reviewed with R13 and family, and indicated a copy of the FDA's "A Guide to Bed Safety," had been provided to R13; however, R13's record lacked documentation of a siderail assessment to include measurements.

On May 18, 2022, at approximately 8:40 a.m., CNS-A stated the siderail assessment included in the residents' Master Care Plan, did not include

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	23986	A. BUILDING: _____ B. WING _____	05/19/2022

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ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

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02310	Continued From page 100	02310		

measurements. CNS-A stated she would conduct the siderail assessment but was not aware of the FDA recommendations to measure the zones to ensure the safe use of the siderails.

The licensee's Safety Rail policy, dated April 20, 2021, indicated the registered nurse (RN) would perform siderail evaluations on a regular basis and include data collection analysis and determination of potential alternatives to siderail use. When siderails were deemed necessary and appropriate, the facility would provide education to resident or resident's representative pertaining to the risk and benefits of siderail use. The facilities priority is to ensure safe and appropriate siderail use. The policy did not address Food and Drug Administration (FDA's) guidelines or documenting measurements according to the FDA.

The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle.

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

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02310	Continued From page 101 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". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to ensure the required notice to visitors was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all 33 current clients, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	03090		

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ELDERWOOD OF HINCKLEY	710 SPRING LANE HINCKLEY, MN 55037

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03090	Continued From page 102 the residents). The findings include: On May 17, 2022, at approximately 11:20 a.m., during the tour of the facility, the surveyor observed cameras throughout the facility, but no electronic monitoring notice posted on entry or in the facility with the statutory required language. On May 17, 2022, at approximately 12:17 p.m., clinical nurse supervisor (CNS)-A acknowledged the licensee failed to post the required electronic monitoring notice. CNS-A stated, " the cameras aren't active and haven't worked for years." However, licensee continued to require video consent forms be completed by all staff and residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: *05/17/22*
Time: 11:30:00
Report: 1016221097

Food and Beverage Establishment Inspection Report

Location:
Elderwood Of Hinckley
710 Spring Lane
Hinckley, MN55037
Pine County, 58

Establishment Info:
ID #: 0037716
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3203847373
ID #:

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

The following orders were issued during this inspection.

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

A HAND WASHING REMINDER SIGN WAS NOT POSTED AT HAND WASHING SINK. INSPECTOR PROVIDED A SIGN TO STAFF.

Comply By: 05/17/22

Surface and Equipment Sanitizers

Hot Water: = at 161 Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 169 Degrees Fahrenheit - Location: YAMS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 140 Degrees Fahrenheit - Location: BEEF
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: GRAPES
Violation Issued: No

Type: Full
Date: *05/17/22*
Time: 11:30:00
Report: 1016221097
Elderwood Of Hinckley

Food and Beverage Establishment Inspection Report

Process/Item: Walk-In Cooler
Temperature: 37 Degrees Fahrenheit - Location: STRAWBERRIES
Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

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

COMMENTS:

PASTEURIZED EGGS ON HAND.

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1016221097 of 05/17/22.

Certified Food Protection Manager: MALINDA MACMAHON

Certification Number: FM104414 Expires: 09/27/23

Signed: _____
MALINDA MACMAHON

Signed: _____
Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us

Report #: 1016221097

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
11 East Superior St.
Duluth

No. of RF/PHI Categories Out	1	Date	05/17/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Elderwood Of Hinckley	710 Spring Lane	Hinckley, MN	55037	3203847373

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037716		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 05/20/22

Inspector (Signature)