DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 24, 2022

Administrator
Saint Therese Residence
8008 Bass Lake Road
New Hope, MN 55428

RE: Project Number(s) SL20141015

Dear Administrator:

On May 18, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on March 2, 2022. The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the March 2, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on March 2, 2022, found not corrected at the time of the May 18, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0970-Waivers Of Liability Prohibited-144.50 Subd. 5 = $500.00
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) = $500.00
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on May 18, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:
Level 1: no fines or enforcement.

Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 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.

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,

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
	20141	A. BUILDING: _____ B. WING _____	R 05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE RESIDENCE	8008 BASS LAKE ROAD NEW HOPE, MN 55428

(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 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20141015-1 On May 17, 2022, through May 18, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on March 2, 2022. At the time of the survey, there were 147 residents: 70 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 430} SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	{0 430}		

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{0 430}	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to four of seven residents (R1, R2, R5, R17) 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:	{0 430}		

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{0 430}	Continued From page 2 On May 9, 2022, interim licensed assisted living director (ILALD)-C provided the surveyor with a document titled UDALSA Audit, dated April 11, 2022. The document showed over 50 residents lacked an UDALSA in their medical record. R1 R1 admitted for service on January 5, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's Service Plan dated July 7, 2021, indicated R1 received assistance with medication administration, housekeeping and laundry. R2 R2 admitted for services on April 21, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's Service Plan dated October 5, 2021, indicated R2 received services for medication management, safety checks, vital signs weekly, bathing, escorts, blood sugar checks, personal care and compression stocking assistance. R5 R5 admitted to licensee on February 19, 2019, and received housing services only. R17 R17 admitted to licensee on February 1, 2019, and received housing services only. R1, R2, R5, and R17's records lacked UDALSA to include: - a disclosure of the categories of assisted living licenses available and the category of license	{0 430}		

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{0 430}	Continued From page 3 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 17, 2022, at approximately 12:03 p.m., ILALD-C stated licensee had completed a UDALSA audit of all residents in the building and resident's records that lacked a UDALSA were sent a copy to sign and return. In addition, ILALD-C stated licensee did not know if would be challenging to have forms returned. ILALD-C acknowledged R1, R2, R5, and R17 lacked a UDALSA and lacked documentation why a written acknowledgement could not be obtained. No further information provided.	{0 430}		
{0 450} SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced	{0 450}		

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{0 450}	Continued From page 4 by: Based on interview and record review, the licensee failed to provide the current Bill of Rights for Assisted Living to three of seven residents (R2, R7, R17) 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: On May 9, 2022, interim licensed assisted living director (ILALD)-C provided the surveyor with a document titled Resident Bill of Rights Audit, dated April 11, 2022. The document showed over 30 residents lacked a current Bill of Rights for Assisted Living in their medical record. R2 R2 admitted for services on April 21, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R7 R7 admitted to licensee on May 28, 2021, and received housing services only. R17 R17 admitted to licensee on February 1, 2019, and received housing services only. R2, R7, and R17's records lacked evidence that the Assisted Living Bill of Rights had been	{0 450}		

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{0 450}	Continued From page 5 received. On May 17, 2022, at approximately 12:03 p.m., ILALD-C stated licensee had completed an Assisted Living Bill of Rights audit of all residents in the building and resident's records that lacked an Assisted Living Bill of Rights were sent a copy to sign and return. In addition, ILALD-C stated licensee did not know if would be so challenging to have forms returned. ILALD-C acknowledged R2, R7, and R17 lacked an Assisted Living Bill of Rights and lacked documentation why a written acknowledgement could not be obtained. The licensee's Minnesota Bill of Rights for Assisted Living Residents dated August 1, 2021, read, "A written acknowledgement of your receipt of the Bill of Rights will be retained in your resident record. If a written acknowledgment cannot be obtained, the reason will be documented in the resident record." No further information provided.	{0 450}		
{0 970} SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the	{0 970}		

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{0 970}	Continued From page 6 licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for two of two residents (R17, R18) 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: On May 17, 2022, interim licensed assisted living director (ILALD)-C provided surveyor with a blank revised contract titled Saint Therese Residency Agreement. The blank contract indicated the licensee would not be liable to resident or resident's guests for any injury, death or property damage occurring in the apartment or on licensee's premises unless such injury, death or property damage occurs as the result of a equipment malfunction or hazardous conditions within the building not caused by resident or resident's guests. R17 R17 admitted to licensee on February 1, 2019, and received housing services only. R17's Residency Agreement was signed July 21, 2021. Residency Agreement on page 14, included a clause that indicated licensee would not be liable to resident for any injury, death or property damage occurring in the apartment or on the licensee's premises.	{0 970}		

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{0 970}	Continued From page 7 R18 R18 admitted to licensee on January 18, 2022, and began receiving assisted living services. R18's Residency Agreement was signed January 14, 2022. Residency Agreement on page 14, included a clause that indicated licensee would not be liable to resident for any injury, death or property damage occurring in the apartment or on the licensee's premises. On May 17, 2022, at approximately 1:15 p.m., ILALD-C acknowledged all licensee's resident agreements contained liability wavier language as indicated above. ILALD-C stated they attempted to talk to corporate to have the wavier of liability removed however, corporate chose to keep the language in the contract. In addition, ILALD-C stated licensee had not issued new contracts to any of the residents and were only using the new contract for new admissions. No further information provided.	{0 970}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	{01620}		

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{01620}	Continued From page 8 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for three of three residents (R13, R14, R18) 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 of the residents). The findings include: R13 R13 admitted to licensee on November 14, 2020, under the comprehensive home care license and began receiving assisted living services on August 1, 2021.	{01620}		

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{01620}	Continued From page 9 R13's Assisted Living Service Plan dated June 9, 2021, indicated R13 received services for laundry, housekeeping, safety checks, medication set up, medication administration, diabetic management, catheter management, home health aide visits and nursing assessments. R13's record indicated the RN completed ongoing 90-day assessments on June 8, 2021, and September 30, 2021. R13's chart lacked recent 90-day assessments which indicated 229 days had passed since last documented assessment. R14 R14 admitted to licensee on November 28, 2021, and began receiving assisted living services. R14's Individualized Service Plan dated June 9, 2021, indicated R14 received services for laundry, housekeeping, safety checks, medication set up, medication administration, diabetic management, toileting assistance, bathing, home health aide visits and nursing assessments. R14's record indicated the RN completed ongoing 90-day assessments on November 26, 2021, and December 13, 2021. R13's chart lacked recent 90-day assessments which indicated 155 days had passed since last documented assessment. R18 R18 admitted to licensee on January 18, 2022, and began receiving assisted living services. R18's Individualized Service Plan dated October 5, 2021, indicated R18 received services for laundry, housekeeping, safety checks, medication set up, medication administration, bathing, home health visit and nursing assessments.	{01620}		

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{01620}	Continued From page 10 R18's record indicated the RN completed an admission assessment on January 17, 2022, and a 14-day assessment on January 31, 2022. R18's record lacked further assessments which indicated 106 days had passed since last documented assessment. On May 17, 2022, at approximately 2:35 p.m., RN-K acknowledged R13, R14 and R18's 90-day assessments were past due. RN-K stated turnover of staff affected assessment completion however, nursing has been working to keep assessments up to date. In addition, RN-K stated there is a tool to assist nurses to know when assessments are due. The licensee's Nursing Assessment; Initial and On-going policy, dated February 18, 2021, indicated the RN would reassess the resident and update the service plan based on the resident's needs and at a frequency not to exceed 90 days from the last date of the assessment. No further information provided.	{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	{01650}		

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{01650}	Continued From page 11 (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the service plan contained all the required content for three of three residents (R13, R14, R18) 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: On May 17, 2022, at 310 p.m., interim licensed assisted living director (ILALD)-C provided	{01650}		

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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
{01650}	Continued From page 12	{01650}		

surveyor a blank Assisted Living Service Plan & Agreement. The Assisted Living Service Plan & Agreement lacked a method for monitoring assessments of the residents and lacked methods of monitoring staff providing services. ILALD-C indicated this was the service plan template used for admitting residents.

R13
R13 admitted to licensee on November 14, 2020, under the comprehensive home care license and began receiving assisted living services on August 1, 2021.

R13's Assisted Living Service Plan dated June 9, 2021, indicated R13 received services for laundry, housekeeping, safety checks, medication set up, medication administration, diabetic management, catheter management, home health aide visits, and nursing assessments. R13's Assisted Living Service Plan lacked the following content:
- methods of monitoring staff providing services; and
-methods of monitoring assessments of the residents.

R14
R14 admitted to licensee on November 28, 2021, and began receiving assisted living services.

R14's Individualized Service Plan dated June 9, 2021, indicated R14 received services for laundry, housekeeping, safety checks, medication set up, medication administration, diabetic management, toileting assistance, bathing, home health aide visits, and nursing assessments. R14's Individualized Service Plan lacked the following content:
- methods of monitoring staff providing services;

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	20141	A. BUILDING: _____ B. WING _____	R 05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01650}	Continued From page 13 and -methods of monitoring assessments of the residents. R18 R18 admitted to licensee on January 18, 2022, and began receiving assisted living services. R18's Individualized Service Plan dated October 5, 2021, indicated R18 received services for laundry, housekeeping, safety checks, medication set up, medication administration, bathing, home health visit, and nursing assessments. R18's Individualized Service Plan lacked the following content: - methods of monitoring staff providing services; and -methods of monitoring assessments of the residents. On May 17, 2022, at approximately 3:10 p.m., ILALD-C acknowledged all residents service plans lacked the above content. The licensee's Content of Service Plan policy, dated February 1, 2021, indicated the service plan would include methods of monitoring reviews or re-assessments of the resident and the frequency of supervision of staff providing services. No further information was provided.	{01650}		
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer	{01910}		

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{01910}	Continued From page 14	{01910}		

part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.
(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.
(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of two discharged residents (R16) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

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{01910}	Continued From page 15 R16 discharged from licensee on March 31, 2022. R16's Independent/Catered Living Service Plan dated December 3, 2020, indicated R18 received services for delegated tasks, medication administration, supervisory visit and nursing assessments. R16's unsigned physician orders dated August 14, 2019, included the following medications: memantine 10 milligrams (mg), metoprolol succinate extended release 25 mg, olanzapine 5mg, quetiapine 25mg, and Vitamin D2 1 tablet. R16's record lacked evidence of documentation of R16's disposition of medications to include name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On May 17, 2022, at 11:24 a.m., registered nurse (RN)-K confirmed R16's record lacked a medication disposition. RN-K stated medication disposition was an issue that had not been fixed prior to RN-K's employment. The licensee's Disposition or Disposal of Medication policy, dated February 19, 2021, indicated licensee would document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication, and the amount of medication remaining. No further information was provided.	{01910}		

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{01940}	Continued From page 16	{01940}		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individual treatment management plan to include	{01940}		

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{01940}	Continued From page 17 all required content for one of one resident (R18) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R18 admitted to licensee on January 18, 2022, and began receiving assisted living services. R18's diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), dementia without behavioral disturbance, major depression and hypertension. R18's Individualized Service Plan dated October 5, 2021, indicated R18 received services for laundry, housekeeping, safety checks, medication set up, medication administration, bathing, home health visit and nursing assessments. On May 19, 2022, at approximately 9:35 a.m., R18 stated they used oxygen as needed which occurred mainly during the overnight hours. In addition, R18 stated staff assist with oxygen use. On May 18, 2022, at approximately 9:45 a.m., the surveyor observed R18 was not wearing oxygen, however six portable oxygen tanks were secured in a carrier in R18's living room and one oxygen concentrator was located in R18's bedroom.	{01940}		

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{01940}	Continued From page 18 R18's care plan dated January 18, 2022, indicated R18 used oxygen. R18's Treatment/Therapy Management Plan lacked the following content: - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documenting of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On May 18, 2022, at approximately 10:55 a.m., registered nurse (RN)-K confirmed R18's record lacked a complete individualized treatment and therapy plan. The licensee's Development of the Individualized Treatment and Therapy Plan and Individualized Treatment Administration Record policy dated February 19, 2022, indicated based on the comprehensive nursing assessment the RN would develop and implement and individualized treatment and therapy management plan for each resident who received any type of treatment or therapy. In addition, the individualize treatment and therapy plan would include the content listed above. No further information was provided.	{01940}		

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{01960}	Continued From page 19	{01960}		
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure treatments or therapies were documented accurately in the medical record for one of one resident (R18) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R18 admitted to licensee on January 18, 2022, and began receiving assisted living services. R18's diagnoses included chronic obstructive	{01960}		

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{01960}	Continued From page 20 pulmonary disease (COPD), congestive heart failure (CHF), dementia without behavioral disturbance, major depression and hypertension. R18's Individualized Service Plan dated October 5, 2021, indicated R18 received services for laundry, housekeeping, safety checks, medication set up, medication administration, bathing, home health visit and nursing assessments. On May 19, 2022, at approximately 9:35 a.m., R18 stated they used oxygen as needed which occurred mainly during the overnight hours. In addition, R18 stated staff assist with oxygen use. On May 18, 2022, at approximately 9:45 a.m., the surveyor observed R18 was not wearing oxygen, however six portable oxygen tanks were secured in a carrier in R18's living room and one oxygen concentrator was located in R18's bedroom. R18's care plan dated January 18, 2022, indicated R18 used oxygen. R18's medication administration record (MAR), dated May 1, 2022, to May 31, 2022, included the following order: oxygen (O2) 1liter (L) via nasal cannula (NC) as needed (PRN) to keep saturation (sats) above (>) 88 percent (%) and may titrate up to 2 L to keep sats > 88 % add hydration/bubbler to O2 as needed for COPD. R18's MAR listed three (3) scheduled times. In addition, the MAR indicated oxygen was administered with a check mark. R18's medication administration record lacked the following documentation: - oxygen saturation of resident; - liter flow rate administered to resident; and - times oxygen was administered to resident.	{01960}		

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{01960}	Continued From page 21 On May 18, 2022, at approximately 10:58 a.m., registered nurse (RN)-K confirmed R18's record lacked the above content. RN-K stated the PRN O2 order should include the content above to accurately show resident's oxygen levels and amount of oxygen resident received. In addition, RN-K stated the licensee had complications with the treatment administration record (TAR), therefore the orders were moved to the MAR to ensure unlicensed personnel could view the order. The licensee's Documentation of Treatment and Therapy Services on the TAR policy, dated March 1, 2021, indicated licensee would document immediately on the resident's TAR after completion of task according to professional standards of documentation. No further information was provided.	{01960}		

Electronically Delivered

March 21, 2022

Administrator
St Therese Residence
8008 Bass Lake Road
New Hope, MN 55428

RE: Project Number(s) SL20141015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 2, 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 - 1650 - 144g.70 Subd. 4 (f) - Service Plan, Implementation And Revisions To - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order 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 reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

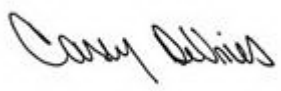
Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 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
Email: casey.devries@state.mn.us
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HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#20141015 On, February 28, 2022, through March 2, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 140 residents; 54 receiving services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on March 1, 2022, issued for SL20141015, tag identification 1650. On March 2, 2022, the immediacy of correction order 1650 was removed, however non-compliance remained at a scope and level of G.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1. Conditions	0 250		

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ST THERESE RESIDENCE	8008 BASS LAKE ROAD NEW HOPE, MN 55428

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0 250	Continued From page 1 (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 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;	0 250		

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	20141	A. BUILDING: _____ B. WING _____	03/02/2022

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0 250	Continued From page 2 (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure by attesting the managerial officials who were in charge of the day-to-day operations developed and implemented current policies and procedures as required with records reviewed. This had the potential to affect all 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: During the entrance conference on February 28, 2022, at approximately 11:45 a.m., interim licensed assisted living director (ILALD)-C and executive director (ED)-D stated they were familiar with the Assisted Living laws and	0 250		

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0 250	Continued From page 3 regulations. The licensee's "Application for Assisted Living License," section titled, "Official Verification of Owner or Authorized Agent" (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17; - I have read and fully understand Minn. Stat. sect. 144G.80 144G.81 and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable; - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G; - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final); - Reporting of Maltreatment of Vulnerable Adults; - Electronic Monitoring in Certain Facilities; - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. Chapter 144G and Minnesota Rules, chapter 4659 (proposed and not final) governing the provision of assisted living facilities and understand as the licensee I am legally responsible for the management, control, and	0 250		

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0 250	Continued From page 4 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"; and - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 (proposed and not final) in place upon licensure and to keep them current as applicable." Page five was electronically signed by Kali Blaeser on May 28, 2021. Refer to licensing order at Statute 144G.40 Subd. 2. The licensee failed to provide licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to three of three residents (R1, R2, R3). Refer to licensing order at Statute 144G.41.1 Subd. 1. The licensee failed to provide the current bill of rights for assisted living to six of six residents (R1, R2, R3, R5, R6, R7). Refer to licensing order at Statute 144G.41 Subd. 7. The licensee failed to post the required information related to the grievance procedure. Refer to licensing order at Statute 144G.42 Subd. 2. The licensee failed to implement and maintain	0 250		

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0 250	Continued From page 5 a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. Refer to licensing order at Statute 144G.42 Subd. 6. The licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for six of six residents (R1, R2, R3,R5, R6, R7). Refer to licensing order at Statute 144G.42 Subd. 9. The licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to provide TB training for two of three employees (registered nurse (RN)-A and unlicensed personnel (ULP)-B). Refer to licensing order at Statute 144G.42 Subd. 10. The licensee failed to develop a written plan of action to facilitate the management of the resident's care and services in response to a natural disaster, such as storms or other emergencies that may disrupt the licensee's ability to provide care and services. In addition, the licensee failed to develop an all-hazards emergency preparedness program and plan to include Appendix Z required elements. Refer to licensing order at Statute 144G.43 Subd. 3. The licensee failed to complete a discharge summary for one of one discharged resident (R4). Refer to licensing order at Statute 144G.45 Subd. 2 (a) (1). The licensee failed to provide smoke alarms in all the bedrooms of apartments and ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the	0 250		

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0 250	Continued From page 6 dwelling to actuate as required. Refer to licensing order at Statute 144G.45 Subd. 2 (a) (4). The licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. Refer to licensing order at Statute 144G.45 Subd. 2 (b) (f). The licensee failed to provide the required fire safety training and evacuation plans for residents and staff. Refer to licensing order at Statute 144G.50 Subd. 5. The licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for six of six residents (R1, R2, R3, R5, R6, R7). Refer to licensing order at Statute 144G.61 Subd. 2. The licensee failed to ensure training was completed in all required areas for one of two employees (ULP-B). Refer to licensing order at Statute 144G.61 Subd. 2. The licensee failed to ensure training and competency was completed for one of two employees (ULP-B) to include all required content. Refer to licensing order at Statute 144G.63 Subd. 2. The licensee failed to ensure employees received orientation to 144G licensing requirements for three of three employees (RN-A, ULP-B, ULP-F). Refer to licensing order at Statute 144G.64. The licensee failed to ensure three of three employees (RN-A, ULP-B, ULP-F) received the	0 250		

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0 250	Continued From page 7 required amount of dementia care training in the required time frame. Refer to licensing order at Statute 144G.70 Subd. 2. The licensee failed to ensure the RN completed a 14-day reassessment for one of three residents (R2) and 90 day reassessments not to exceed 90 days for three of three residents (R1, R2, R3). Refer to licensing order at Statute 144G.70 Subd. 4(f). The licensee failed to ensure the memory care was always secured per memory care service plan and agreement for two of three residents (R3, R9). Additionally, the licensee failed to develop a contingency plan that included the action to be taken if the scheduled service could not be provided if the secured memory care unit was unable to be secured and the requirements for two of three residents' service plans could not be met. Refer to licensing order at Statute 144G.71 Subd. 2. The licensee failed to ensure the RN conducted a face-to-face medication management assessment, prior to providing medication management services, to include all required content for one of four residents (R9). Refer to licensing order at Statute 144G.71 Subd. 5. The licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of two residents (R2, R3). Refer to licensing order at Statute 144G.71 Subd. 8. The licensee failed to transcribe provider orders timely, ensure medications were administered per providers orders, and follow the process of medication administration for two of	0 250		

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0 250	Continued From page 8 three residents (R2, R8). Refer to licensing order at Statute 144G.71 Subd. 19. The licensee failed to ensure prescription medications were stored according to the manufacturer's directions. Refer to licensing order at Statute 144G.71 Subd. 20. The licensee failed to ensure time sensitive medication were labeled with the date opened, dispose of expired medications, and ensure medications were maintained bearing the original prescription label with legible information for two of four residents (R2, R8). Refer to licensing order at Statute 144G.71 Subd. 22. The licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R4). Refer to licensing order at Statute 144G.72 Subd. 3. The licensee failed to develop an individual treatment management plan to include all required content for one of one resident (R2). Refer to licensing order at Statute 144G.72 Subd. 4. The licensee failed to ensure treatments or therapies were administered as prescribed, or to document the reason they were not provided to meet the resident's needs for one of one resident (R2) with supplemental oxygen monitoring managed by the provider. Refer to licensing order at Statute 144G.81 Subd. 1. The licensee failed to conduct a hazard vulnerability or safety risk assessment on or	0 250		

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0 250	Continued From page 9 around the facility property. Refer to licensing order at Statute 144G.91 Subd. 4. The licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to accepted health care and medical, or nursing standards for two of three residents (R1, R2). Refer to licensing order at Statute 144G.6502 Subd.10. The licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. Thirty (30) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. 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 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	0 430		

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0 430	Continued From page 10 provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide 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 January 5, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's Service Plan dated July 7, 2021, indicated R1 received assistance with medication administration, housekeeping and laundry.	0 430		

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0 430	Continued From page 11 On March 2, 2022, at approximately 10:00 a.m., the surveyor observed unlicensed personnel (ULP)-F administer R1's oral medications. 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 21, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's Service Plan dated October 5, 2021, indicated R2 received services for medication management, safety checks, vital signs weekly, bathing, escorts, blood sugar checks, personal care and compression stocking assistance. On March 1, 2022, at approximately 9:17 a.m., the surveyor observed ULP-B provide medication administration services to R2. 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 under the facility's license, identifying all services the facility offers to provide under the assisted	0 430		

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0 430	Continued From page 12 living facility contract, and identifying all services allowed under the license that the facility does not provide. R3 R3 admitted for service on September 19, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R3's Service Plan dated July 25, 2019, indicated R3 received services for 24/7 home health aide assistance, weekly medication reminders and assists, laundry services, linen changes, meals, activities specially programmed for individuals with dementia-related illness, wander guard and/or emergency pendant, labs and medication management. On March 1, 2022, at approximately 10:00 a.m., the surveyor observed ULP-G provide toileting services to R3. 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 March 2, 2022, at approximately 10:50 a.m., executive director (ED)-D stated 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	0 430		

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0 430	Continued From page 13 disclosure. The licensee lacked a policy regarding the UDALSA. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current bill of rights for assisted living to six of six residents (R1, R2, R3, R5, R6, R7) 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	0 450		

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0 450	Continued From page 14 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 services on January 5, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's record lacked evidence R1 had received the Assisted Living Bill of Rights. R2 R2 admitted for services on April 21, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's record lacked evidence R2 had received the Assisted Living Bill of Rights. R3 R3 admitted for service on September 19, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R3's record lacked evidence R3 had received the Assisted Living Bill of Rights. R5 The licensee's current resident roster indicated R5 received housing services only. On March 2, 2022, at approximately 9:00 a.m., R5 stated the only service she received was housekeeping.	0 450		

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0 450	Continued From page 15 R5's record lacked evidence R5 had received the Assisted Living Bill of Rights. R6 R6's Service Plan dated July 21, 2021, indicated R6 received housing services only. R6's record lacked evidence R6 had received the Assisted Living Bill of Rights. R7 The licensee's current resident roster indicated R7 received housing services only. R7's record lacked evidence R7 had received the Assisted Living Bill of Rights. On March 2, 2022, at approximately 10:50 a.m., executive director (ED-D) confirmed R1, R2, R3, R5, R6, R7 and all residents receiving assisted living services and housing only services had not received the Assisted Living Bill of Rights. The licensee's Minnesota Bill of Rights for Assisted Living Residents dated August 1, 2021, read, "A written acknowledgement of your receipt of the Bill of Rights will be retained in your resident record. If a written acknowledgment cannot be obtained, the reason will be documented in the resident record." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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	20141	A. BUILDING: _____ B. WING _____	03/02/2022

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0 550	Continued From page 16 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 review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all 140 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 grievance procedure to include the name, telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances. During facility tour on February 28, 2022, at	0 550		

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0 550	Continued From page 17 approximately 12:15 p.m., the surveyor observed the common areas shared by residents, staff and visitors, lacked the required posting of the grievance procedure. On February 28, 2022, at approximately 1:35 p.m., interim licensed assisted living director (ILALD)-C acknowledged the required content was not posted in the common areas. ILALD-C stated the grievance information was previously posted but must have been taken down. The licensee's Grievance Policy dated May 27, 2021, lacked information regarding required posting. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced	0 580		

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0 580	Continued From page 18 by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all 140 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 the residents). The findings include: On February 28, 2022, at approximately 12:00 p.m., interim licensed assisted living director (ILALD)-C stated the licensee was working on falls for their quality management plan. On March 2, 2022, at approximately 2:05 p.m., executive director (ED)-D stated they had no documentation of quality management meetings. The licensee's Quality Management Plan policy dated February 19, 2021, indicated quality council meetings would be held quarterly and minutes of quality council meetings would be summarized for all staff to review. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		

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0 630	Continued From page 19	0 630		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for six of six residents (R1, R2, R3, R5, R6, R7) 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: R1, R2, and R3's individual abuse prevention plan lacked specific measures to be taken to minimize the risk of abuse.	0 630		

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0 630	Continued From page 20 R1 R1's diagnoses included COPD (chronic obstructive pulmonary disease), Alzheimer's disease, anxiety and panic disorder. R1's Service Plan dated July 7, 2021, indicated R1 received assistance with medication administration, housekeeping and laundry. On March 2, 2022, at approximately 10:00 a.m., the surveyor observed unlicensed personnel (ULP)-F administer R1's morning medications. The surveyor observed R1 receiving oxygen per nasal cannula. R1's Vulnerable Adult Assessment dated July 7, 2021, lacked specific measures to be taken to minimize the risk of abuse. On March 2, 2022, at approximately 11:15 a.m., registered nurse (RN)-A confirmed R1's individual abuse prevention plan lacked specific measures to be taken to minimize the risk of abuse. R2 R2's diagnoses included a history of falls, dependence on supplemental oxygen and long-term use of anticoagulants. R2's Service Plan dated October 5, 2021, indicated R2 received services for medication management, safety checks, vital signs weekly, bathing, escorts, blood sugar checks, personal assistance and compression stocking assistance. On March 1, 2022, at approximately 9:17 a.m., the surveyor observed ULP-B provide medication administration services to R2. R2's individual abuse prevention plan did not	0 630		

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0 630	Continued From page 21 include an assessment and interventions to address the following: - the risk of abuse to themselves; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On March 2, 2022, at approximately 2:03 p.m., RN-A confirmed R2's individual abuse prevention plan lacked specific measures to be taken to minimize the risk of abuse to others and risk of abuse to self. R3 R3 had a diagnosis of dementia without behavior disturbance and dementia with behavioral disturbance. R3's Service Plan dated July 25, 2019, indicated R3 received services for 24/7 home health aide assistance, weekly medication reminders and assists, laundry services, linen changes, meals, activities specially programmed for individuals with dementia-related illness, wander guard and/or emergency pendant, labs and medication management. On March 1, 2022, at approximately 10:00 a.m., the surveyor observed ULP-G provide toileting services to R3. R3's Vulnerable Adult Assessment dated October 13, 2021, lacked specific measures to be taken to minimize the risk of abuse. On March 2, 2022, at approximately 1:59 p.m., RN-A confirmed R3's individual abuse prevention plan lacked specific measures to be taken to minimize the risk of abuse.	0 630		

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0 630	Continued From page 22 R5, R6, and R7's record lacked an individual abuse prevention plan. R5 The licensee's current resident roster indicated R5 received housing services only. On March 2, 2022, at approximately 10:00 a.m., R5 stated she only received housing service. R5's record lacked evidence the licensee completed an individual abuse prevention plan. R6 The licensee's current resident roster indicated R6 received housing services only. R6's record lacked evidence the licensee completed an individual abuse prevention plan. R7 The licensee's current resident roster indicated R7 received housing services only. R7's record lacked evidence the licensee completed an individual abuse prevention plan. On March 2, 2022, at approximately 10:50 a.m., ED-D stated R5, R6, R7 and all residents receiving housing only services records lacked evidence an individual abuse prevention plan had been completed. The licensee's Individual Abuse Prevention Plans policy dated November 29, 2021, indicated all assisted living residents will have and individual abuse prevention plan developed, and will include specific measures to minimize the risk of abuse to that person and other vulnerable adults.	0 630		

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0 630	Continued From page 23 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to provide TB training for two of three employees (registered nurse (RN)-A and unlicensed personnel (ULP)-B) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 660		

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0 660	Continued From page 24	0 660		

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:

RN-A
RN-A was hired on August 30, 2021, to provide direct care and supervision of care to residents and supervision of unlicensed personnel.

On February 28, 2022, through March 2, 2022, the surveyor observed RN-A provide supervision of unlicensed personnel (ULP) and residents.

RN-A's employee record lacked evidence of required TB training at the time of hire.

ULP-B
ULP-B was hired on January 11, 2021, to provide direct care services to licensee's residents.

On March 1, 2022, at approximately 9:17 a.m., the surveyor observed ULP-B provide medication administration services to R2.

ULP-B's employee record lacked evidence of required TB training at the time of hire.

On March 2, 2022, at approximately 10:50 a.m., executive director (ED)-D confirmed RN-A and ULP-B had not received TB training at the time of hire.

The licensee's Infection Prevention and Control

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0 660	Continued From page 25 Program policy revised August 2019 did not include TB training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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	0 680		

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0 680	Continued From page 26 by: Based on interview and record review, the licensee failed to develop a written plan of action to facilitate the management of the resident's care and services in response to a natural disaster, such as storms or other emergencies that may disrupt the licensee's ability to provide care and services. In addition, the licensee failed to develop an all-hazards emergency preparedness program and plan to include Appendix Z required elements. 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: On February 28, 2022, at approximately 11:26 a.m., the surveyor requested to review the licensee's emergency preparedness plan and Appendix Z. The licensee lacked an emergency preparedness and Appendix Z plan to manage the resident's care and services in response to a disaster or emergency. During tour of the facility on February 28, 2022, at approximately 12:34 p.m., the surveyor observed no signage or information posted regarding the licensee's emergency plan or emergency exit diagrams at the facility entrance, on any of the seven floors, hallways, in the dining area or in the living areas.	0 680		

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0 680	Continued From page 27 On February 28, 2022, at approximately 3:06 p.m., plant operations director (POD)-E confirmed the licensee lacked a customized emergency preparedness plan and Appendix Z to include: - a written emergency disaster plan that contained 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; - post an emergency disaster plan prominently; - provide building emergency exit diagrams to all residents; - post emergency exit diagrams on each floor; - emergency and disaster training to all staff during the initial staff orientation; and - Appendix Z required elements. The licensee's Plans for Emergencies and Natural Disasters policy dated February 19, 2021, indicated the licensee would have a written plan of action in place to facilitate the resident's care and services in response to a natural disaster or another type of emergency that may affect licensee's ability to provide services. Additionally, the policy indicated the licensee would update the policy regularly. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone	0 730		

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0 730	Continued From page 28 number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (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	0 730		

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0 730	Continued From page 29 (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to complete a discharge summary for one of one discharged resident (R4) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's service plan dated February 18, 2021, indicated R4 received services for housekeeping, assessments, bathing and medication management. R4 was discharged on November 16, 2021. On March 1, 2022, at 12:20 p.m., registered nurse (RN)-A confirmed the licensee had not completed a discharge summary for R4. RN-A further stated they did not know it was needed when residents transfer to the care center (attached facility, separately licensed). The licensee's Content of Client [Resident] Records policy dated February 18, 2021, indicated when a resident transferred to another	0 730		

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0 730	Continued From page 30 provider or services were terminated, a discharge summary would include: - service termination notice, if applicable; - resident's status at the time of transfer or discharge; and - disposition of any medications that the licensee controlled or stored. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in	0 780		

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0 780	Continued From page 31 existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in all the bedrooms of apartments and ensure smoke alarms are interconnected so that the actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 residents). The findings include: On February 28, 2022, between 12:30 p.m. and 2:15 p.m., survey staff toured the facility with the plant operations director (POD)-E. During the facility tour, survey staff observed no smoke alarms installed in apartment bedrooms. POD-E verbally confirmed survey staff observations during the facility tour. POD-E stated the facility has a large remodel scheduled in the next couple of years and will make sure to add hardwired, interconnected smoke alarms to the scope. He also stated he will install battery-operated, interconnected smoke alarms in all the apartments per statute as soon as possible. The building is fully sprinklered.	0 780		

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0 780	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On February 28, 2022, from approximately 12:30 p.m to 2:15 p.m., survey staff toured the facility with the plant operations director (POD)-E.	0 800		

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0 800	Continued From page 33 During the facility tour, survey staff observed the following: 1. Seventh-floor window and light fixture in the common space by room 717 were filled with flies, both living and dead. 2. Seventh-floor shower room ran brown water from the sink. 3. Sixth floor and fourth-floor shower room fan damper was not working. POD-E removed the cover plate and exposed fans and dampers; all were covered in lint which was inhibiting their proper function. 4. Ceiling tiles in the country store on the first floor were damaged and some tiles were completely missing. 5. Ceiling was damaged in the hallway by the salon. POD-E stated they had a water leak in the past and hadn't been able to fix the ceiling yet. 6. First-floor laundry room ceiling was damaged. POD-E stated there had been a leaking drain line that was fixed, but he had not repaired the ceiling yet. 7. Ceiling tiles in the rehab office were stained and damaged. 8. Ceiling tiles in the hallway by room 124 were stained and damaged. 9. Ground floor meter room had items being stored in front of the electrical panels. 10. Ceiling damage outside ground floor storage rooms.	0 800		

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0 800	Continued From page 34 11. Room 023 had ceiling damage outside the show. 12. Sprinkler heads in all laundry rooms had lint build-up. 13. Trash chute doors on floors 7, 6, 5, 4, 3, and 2 did not close and latch on their own. 14. Storage closets on floors 7, 6, 5, 4, 3, and 2 were filled and obstructed the sprinkler head on each floor. The second-floor storage room had a kiln. MDH recommends contacting the local fire official to obtain proper documentation on procedures for having and using a kiln in a high-rise building. POD-E verbally confirmed survey staff observations during the facility tour. 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	0 810		

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0 810	Continued From page 35 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).	0 810		

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0 810	Continued From page 36 The findings include: On February 28, 2022, from approximately 12:30pm to 2:15 p.m., survey staff toured the facility with the plant operation director (POD)-E. During the facility tour, survey staff observed the posted evacuation plans did not include the dementia care suites on the seventh floor. POD-E verbally confirmed survey staff observations during the facility tour. During the interview on February 28, 2022, at 3:10 p.m., POD-E stated they were not doing employee or resident training on fire safety or evacuation. A review of the fire safety manual showed the following: 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar emergency. No written instructions for addressing any unique or unusual resident needs or including the needs of residents who may be wheelchair-bound or have other needs during an evacuation. 2. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. 3. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation.	0 810		

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0 810	Continued From page 37 4. Fire safety and evacuation plans that showed the location and number of resident rooms were outdated and did not include the dementia care suites on the seventh floor. Posted evacuation diagrams were dated 2018. POD-E confirmed documentation of fire safety and evacuation policy and procedures were incomplete. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident for six of six residents (R1, R2, R3, R5, R6, R7) 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	0 970		

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0 970	Continued From page 38	0 970		

resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R1
R1 admitted for service on January 5, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021.

R1's Residency Agreement was signed July 22, 2022.

R2
R2 admitted for service on April 21, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021.

R2's Residency Agreement was signed October 5, 2021.

R3
R3 admitted for service on September 19, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021.

R3's Residency Agreement was signed July 22, 2021.

R1, R2, and R3's Residency Agreement included a clause that indicated the owner was not liable to resident for any injury, death or property damage occurring in the apartment or on owner's premises unless such injury, death or property

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0 970	Continued From page 39 damage occurred as the result of an equipment malfunction or hazardous conditions within the building not caused by resident. The agreement also indicated the owner was also not liable for any injury, death or damage occurring as the result of resident's receipt of health-related, supportive, or other services from third party providers, owner may be liable to resident for its own negligent acts or those of its employees or agents, and unless caused by one of the aforementioned excepted reasons, resident agreed to hold owner harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the apartment or on owner's premises. R5 R5 was admitted on January 5, 2019, to receive housing only services. R5's Residency Agreement was signed July 21, 2022. R6 R6 was admitted on July 8, 2019, to receive housing only services. R6's Residency Agreement was signed July 21, 2021. R7 R7 was admitted on January 5, 2019, to receive housing only services. R7's Residency Agreement was signed July 26, 2021. R5, R6, and R7 Residency Agreement included a clause that indicated the owner was not liable to	0 970		

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0 970	Continued From page 40 resident for any injury, death or property damage occurring in the apartment or on owner's premises unless such injury, death or property damage occurred as the result of an equipment malfunction or hazardous conditions within the building not caused by resident. The agreement also indicated the owner was also not liable for any injury, death or damage occurring as the result of resident's receipt of health-related, supportive, or other services from third party providers, owner may be liable to resident for its own negligent acts or those of its employees or agents, and unless caused by one of the aforementioned excepted reasons, resident agreed to hold owner harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the apartment or on owner's premises. On March 2, 2022, at approximately 10:50 a.m., interim licensed assisted living director (ILALD)-D stated all licensee's resident agreements contained liability wavier language as indicated above. The licensee's Assisted Living Contract policy requested but was not provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01370 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all	01370		

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01370	Continued From page 41 unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	01370		

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01370	Continued From page 42 Based on observation, interview and record review, the licensee failed to ensure training was completed in all required areas for one of two employees (unlicensed personnel (ULP)-B) 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on January 11, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-B's employee file lacked documentation of training and competency evaluations for the following topics: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums and oral prosthetic devices; (iii) care and use of hearing aides; and (iv) dressing and assisting with toileting. - standby assistance techniques and how to perform them;	01370		

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01370	Continued From page 43 - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the residents family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On March 1, 2022, at approximately 9:17 a.m., the surveyor observed ULP-B provide medication administration services to R2. On March 1, 2022, at approximately 3:38 p.m., executive director (ED)-D confirmed ULP-B's personnel file did not contain documentation ULP-B completed training in all required areas. The licensee's Unlicensed Personnel - Training and Competency Evaluation policy dated February 24, 2021, indicated each personnel file would include a record of all completed training and competency testing for unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01380 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:	01380		

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01380	Continued From page 44 (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of two employees (unlicensed personnel (ULP)-B) to include all required content with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on January 11, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021.	01380		

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01380	Continued From page 45 ULP-B's employee file lacked documentation of training and competency evaluations for the following topics: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. On March 1, 2022, at approximately 9:17 a.m., the surveyor observed ULP-B provide medication administration services to R2. On March 1, 2022, at approximately 3:38 p.m., executive director (ED)-D confirmed ULP-B's personnel file did not contain documentation ULP-B completed training in all required areas. The licensee's Unlicensed Personnel - Training and Competency Evaluation policy dated February 24, 2021, indicated each personnel file would include a record of all completed training and competency testing for unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
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	01470		

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01470	Continued From page 46 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; (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;	01470		

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01470	Continued From page 47 (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 received orientation to 144G licensing requirements for three of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B and ULP-F) with employee records reviewed. This had the potential to affect all fifty-four (54) residents receiving services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 February 28, 2022, at approximately 11:26 a.m., executive director (ED)-D and interim licensed assisted living director (ILALD)-C stated they understood assisted living licensure regulation and requirements.	01470		

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01470	Continued From page 48 RN-A RN-A was hired on August 30, 2021, to provide direct care and supervision of care to residents and supervision of ULP's. On February 28, 2022, through March 3, 2022, the surveyor observed RN-A provide supervision of ULP's and residents. RN-A's employee record lacked evidence RN-A received orientation to the following required topics: - 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 handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - 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 - a review of the types of assisted living services	01470		

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01470	Continued From page 49 the employee will be providing and the facility's category of licensure. ULP-B ULP-B was hired on January 11, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On March 1, 2022, at approximately 9:17 a.m., the surveyor observed ULP-B provide medication administration services to R2. ULP-B's employee record lacked evidence of orientation to the following requirements as part of the orientation to assisted living: - 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; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and	01470		

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01470	Continued From page 50 Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-F ULP-F was hired on October 19, 2015, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On March 2, 2022, at approximately 10:00 a.m., the surveyor observed ULP-F administer R1's morning medications. ULP-F's employee record lacked evidence ULP-F had received orientation to the following required topics: - an overview of this chapter, and - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. On March 2, 2022, at approximately 10:50 a.m., ED-D confirmed RN-A, ULP-B and ULP-F had not received orientation to the following required topics as indicated above. Licensee's Unlicensed Personnel - Training and Competency Evaluation policy dated February 24, 2022, indicated all staff would meet all orientation requirements before providing services to a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01470		

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01470	Continued From page 51 (21) days	01470		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure three of three employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B and ULP-F) received the required amount of dementia care	01530		

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01530	Continued From page 52	01530		

training in the required time frame with records reviewed. This had the potential to affect all 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 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:

RN-A
RN-A was hired on August 30, 2021, to provide direct care and supervision of care to residents and supervision of unlicensed personnel.

On February 28, 2022, through March 3, 2022, the surveyor observed RN-A provide supervision to ULP's and residents.

RN-A's employee record indicated RN-A received the following training:
- different stages of dementia;
- sensory deficits with dementia;
- understanding behaviors;
- getting to know the resident beyond medical needs; and
- responding to residents and difficult behavior.

RN-A's employee records lacked the number of dementia training hours RN-A had completed. It could not be determined if RN-A had completed the required eight hours of dementia training within 120 working hours.

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01530	Continued From page 53 On March 2, 2022, at approximately 10:50 a.m., executive director (ED)-D confirmed RN-A had not completed the required eight (8) hours of dementia training. ULP-B ULP-B was hired on January 11, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On March 1, 2022, at approximately 9:17 a.m., the surveyor observed ULP-B provide medication administration services to R2. ULP-B's employee record indicated ULP-B had completed two (2) of the required eight (8) hours of dementia training within 160 working hours as follows: - dementia training power point/video (2 hour). On March 1, 2022, at approximately 3:38 p.m., ED-D confirmed ULP-B had not completed the required eight (8) hours of dementia training. ULP-F ULP-F was hired on October 19, 2015, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On March 2, 2022, at approximately 10:00 a.m., the surveyor observed ULP-F administer R1's morning medications. ULP-F's employee record indicated ULP-F received the following training: - A day in the life of Henry: A Dementia Experience (0.25 hours);	01530		

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01530	Continued From page 54 - Dementia care Performing ADL's (activities of daily living) (0.5 hours); - Dementia Care Normal Aging versus Dementia/Alzheimer's (0.5 hours); - Teepa Snow: Challenging Behaviors (0.25 hours); - Care of Resident's with Dementia in AL (assisted living) (0.75 hours); - Alzheimer's disease and related disorders: The Physical Environment (1 hour); and - Alzheimer's disease and Related Disorders: Activities (1 hour). ULP-F's employee record indicated ULP-F had completed 4.25 hours of the required eight (8) hours of dementia training within 160 working hours. On March 2, 2022, at approximately 10:50 a.m., ED-D confirmed ULP-F had not completed the required eight (8) hours of dementia training. The licensee's Dementia Care Training for Home Care Staff Providing Home Care Services in Housing with Services Establishments with Dementia Programs and/or Assisted Living Services policy dated March 2, 2021, indicated staff providing direct home care services and supervisors of direct-care staff providing services would be trained in addition to Home Care law to meet requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=F	144G.70 Subd. 2 Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 55 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed a 14-day reassessment for one of three residents (R2) and ongoing resident reassessments did not exceed 90 days for three of three residents (R1, R2, R3) 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	01620		

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01620	Continued From page 56	01620		

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 Service Plan dated July 7, 2021, indicated R1 received assistance with medication administration, housekeeping and laundry.

On March 2, 2022, at approximately 10:00 a.m., the surveyor observed unlicensed personnel (ULP)-F administer R1's oral medications.

R1's record indicated the RN completed a Monitoring Visit on September 20, 2021, and an AL (assisted living) Assessment on February 15, 2022, which indicated 148 days passed between assessments.

On March 2, 2022, at approximately 10:50 a.m., executive director (ED)-D confirmed R1's ongoing reassessments were not completed at least every 90 days.

R2
R2's Service Plan dated October 5, 2021, indicated R2 received services for medication management, safety checks, vital signs weekly, bathing, escorts, blood sugar checks, personal assistance and compression stocking assistance.

On March 1, 2022, at approximately 9:17 a.m., the surveyor observed ULP-B provide medication administration services to R2.

R2's record indicated an RN completed an admission assessment on April 21, 2021, a

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01620	Continued From page 57 14-day assessment on July 12, 2021, and a 90-day assessment on October 14, 2021. R2's record lacked any further assessments. R2's last assessment was completed 134 days prior to survey entrance, 64 days past due. On March 1, 2022, at approximately 1:27 p.m., RN-A confirmed R2's record lacked a 14-day and a 90-day assessment and stated, "it's very difficult when you're the only nurse here." R3 R3's Memory Care Service Plan dated July 25, 2019, indicated R3 received services for 24/7 home health aide assistance, weekly medication reminders and assists, laundry services, linen changes, meals, activities specially programmed for individuals with dementia-related illness, wander guard and/or emergency pendant, labs and medication management. On March 1, 2022, at approximately 10:00 a.m., the surveyor observed ULP-G provide toileting services to R3. R3's record indicated the RN completed AL assessments on October 13, 2021, and February 12, 2022, which indicated 122 days passed between assessments. On March 3, 2022, at approximately 1:59 p.m., RN-A confirmed R3's ongoing reassessments were not completed at least every 90 days. The licensee's Nursing Assessment; Initial and On-going policy dated February 18, 2021, indicated the RN would reassess the resident and update the service plan based on the resident's needs and at a frequency not to exceed 90 days from the last date of the assessment.	01620		

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01620	Continued From page 58 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=G	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	01650		

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01650	Continued From page 59 by: Based on observation, interview and record review, the licensee failed to ensure the memory care was always secured per memory care service plan and agreement for two of three residents (R3, R9) with records reviewed. Additionally, the licensee failed to develop a contingency plan that included the action to be taken if the scheduled service could not be provided if the secured memory care unit was unable to be secured and the requirements for two of three residents' service plans could not be met. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 28, 2022, at approximately 11:30 a.m., during the entrance conference, interim licensed assisted living director (ILALD)-C and executive director (ED)-D stated they had a secured memory care unit that was kept secure with a key. Residents were unable to exit without the assistance of staff members. R3 R3 admitted for service on September 19, 2019. R3 had diagnoses of dementia without behavior disturbance and dementia with behavioral disturbance.	01650	Immediacy is removed as confirmed by surveyor's on-site observation on March 1 and March 2, 2022, and review by evaluation supervisor on March 2, 2022, however noncompliance remained at a scope and level of G.	

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01650	Continued From page 60 R3's Vulnerability Assessment/Abuse Prevention Plan dated October 13, 2021, indicated R3 was confused with severe memory loss, resided in memory care with close 24/7 supervision, and moved in a wheelchair without purpose. R3's Assessment dated February 12, 2022, indicated she resided in memory care. R2 required assistance with bathing, dressing, toileting, grooming, mobility and medication administration. R3's Memory Care Service Plan dated July 25, 2019, indicated R3 received services for 24/7 home health aide assistance, weekly medication reminders and assists, laundry services, linen changes, meals, activities specially programmed for individuals with dementia-related illness, wander guard and/or emergency pendant, labs, and medication management. On March 1, 2022, at approximately 11:12 a.m., the surveyor observed R3 by the exit door. R3 stated, "I have to get out of here." R3 moved the doorknob and was redirected by unlicensed personnel (ULP)-G away from door. On March 1, 2022, at approximately 11:15 a.m., ULP-G stated R3 wandered in the unit with the exception of bedrooms. ULP-G stated, "she makes comments about wanting to go with her daddy, or that her daddy and mother are coming to get her." R9 R9 admitted for services on July 31, 2017. R9's diagnoses included dementia.	01650		

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01650	Continued From page 61 R9's Vulnerability Assessment/Abuse Prevention Plan, dated March 24, 2021, indicated R9 had moderate memory loss and demonstrated inappropriate judgement related to safety. R9 resided in a 24/7 memory care and always had supervision. R9's Assessment dated January 31, 2022, indicated R9 resided in a memory care unit. R9 required assistance with bathing dressing, toileting, and medication administration. R9 Memory Care Service Plan and Agreement, dated September 2, 2020, indicated R9 required a wander guard and/or emergency pendant. On February 28, 2022, at approximately 1:15 p.m., the surveyor observed R9 wandering in the memory care unit and following surveyors and staff members. On March 1, 2022, at approximately 11:15 a.m., ULP-G stated R9 wandered throughout the day and staff needed to ask her to sit down so she did not lose her balance. ULP-G stated, "she wants to go outside or go home but is easily redirected." Licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated June 12, 2021, indicated the licensee provided a secured unit or building for wandering or exit-seeking behavior and wander guard for specified suites. On March 1, 2022, at approximately 10:10 a.m., the surveyor opened door of the secured dementia unit leading to common area. The door did not alert staff they surveyor was exiting. On March 1, 2022, at approximately 10:12 a.m.,	01650		

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01650	Continued From page 62 ULP-G stated the alarm does not work on the exit door. Additionally, ULP-G stated the wander guard bracelet on residents were removed, however she was unsure of why. On March 1, 2022, at approximately 10:15 a.m., maintenance (M)-H confirmed the memory care unit door opened without alert. They stated the system had not been working for some time, however, was unable to give an approximate date. On March 1, 2022, at approximately 10:35 a.m., ILALD-C stated the memory care is a locked unit and staff need to always lock door. ILALD-C confirmed the memory care door did not alert staff when people exited and acknowledged the residents' ability to exit without staff knowledge. ILALD-C confirmed a wander guard or pendant was not present on R3 or R9. They stated they were not sure why pendants or wander guards were not in place. On March 1, 2022, at approximately 12:33 p.m., ILALD-C stated there was a work order to remove the handle of the memory care secured unit door and a second staff person was assigned to the memory care unit until the issue was resolved. ILALD-C and ED-D were unable to state how long the wander guard system had not been functioning. They also were unable to state why and how long residents did not have a wander guard or pendant. They stated they did not have a written emergency plan if the system malfunctioned. On March 1, 2022, at approximately 2:36 p.m., plant operation director (POD-E) stated the wander guard system was not functioning and they would need to order two new boxes. They	01650		

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01650	Continued From page 63 were unsure how long wander guard system had not been functioning and had not received a work order on the wander guard system. POD-E stated they were setting up two alarms to sound when door opened to alert staff of people exiting. The licensee's policy Memory Care Disclosure dated July 2018, read, "All entrances and exits from the memory care neighborhood are controlled by a locked/coded system. If deemed necessary, memory care residents will wear a wander-guard that has the capability to alert employees of movements outside the secured living area." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy was removed as confirmed by surveyor's on-site observation on March 1 and March 2, 2022, and review by evaluation supervisor on March 2, 2022, however noncompliance remained at a scope and level of G. TIME PERIOD FOR CORRECTION: Two (2) days	01650		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what	01700		

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01700	Continued From page 64 medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 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) conducted a face-to-face medication management assessment, prior to providing medication management services, to include all required content for one of four residents (R9) 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	01700		

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01700	Continued From page 65 situation has occurred only occasionally). The findings include: R9 admitted for service on February 1, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R9's diagnoses included dementia without behavioral disturbance and low back pain. R9's service plan dated September 2, 2020, indicated R9 received services for medication management, bathing, housekeeping, home health care services, activities, wander guard and/or emergency pendant and dining services. On March 1, 2022, at approximately 12:00 p.m., the surveyor observed unlicensed personnel (ULP)-G administer medication to R9. On March 2, 2022, at approximately 10:03 a.m., the surveyor observed ULP-G administer medication to R9. On March 2, 2022, at approximately 1:59 p.m., RN-A confirmed R9's record lacked a medication management assessment. The licensee's Content of Client's Medication Records policy dated March 1, 2021, indicated if the agency is managing medications the resident's record must contain an individualized medication management plan developed by the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01700		

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01700	Continued From page 66 days	01700		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of 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.	01730		

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01730	Continued From page 67 (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 two of two residents (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, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 admitted for service on April 21, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's diagnoses included a history of falls, dependence on supplemental oxygen and long-term use of anticoagulants.	01730		

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01730	Continued From page 68 R2's Service Plan dated October 5, 2021, indicated R2 received medication management services. R2's electronic medical record (EMAR) dated February 2022, included the following medications: one diuretic, two blood pressure reducers, one diabetic medication, one stomach acid reducer, one bone loss preventative, two vitamin supplements, one anti-inflammatory and two inhalers. On March 1, 2022, at approximately 9:17 a.m., the surveyor observed ULP-B provide medication administration services to R2. R2's medication management plan lacked the following: - a description of storage of medications based on the residents needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - a statement describing the medication management services that will be provided; - documentation of specific resident instructions relating to the administration of medications; - 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 March 2, 2022, at approximately 3:40 p.m., executive director (ED)-D confirmed R2's individualized medication management plan did not include all the required content. R3	01730		

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01730	Continued From page 69 R3 admitted for service on September 19, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R3 had diagnoses of dementia without behavior disturbance and dementia with behavioral disturbance. R3's Memory Care Service Plan dated July 25, 2019, indicated R3 received services for 24/7 home health aide assistance, weekly medication reminders and assists, laundry services, linen changes, meals, activities specially programmed for individuals with dementia-related illness, wander guard and/or emergency pendant, labs and medication management. R3's Medication Assessment Comprehensive dated August 7, 2020, lacked written procedures for staff to notify a registered nurse (RN) or appropriate licensed health professional when a problem arises. On March 2, 2022, at approximately 1:59 p.m., RN-A confirmed R3's individualized medication management plan lacked written procedures for staff to notify a registered nurse when a problem arises. The licensee's Development of the Individualized Medication Management Plan (IMMP) and Individualized Medication Administration Record (MAR) dated February 19, 2021, indicated the plan will contain the following: - identification of the medication management services to be provided by our agency; - description of how medications managed by our agency will be stored, based on the resident's needs, risk of diversion and consistent with the	01730		

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01730	Continued From page 70 manufacturer's directions; - identification of any specific resident instructions regarding medications our agency staff will administer; - identification of the staff responsible for monitoring medication supplies and ensuring refills are ordered on a timely basis; - identification of the staff who are responsible for the medication management tasks, including tasks delegated to unlicensed staff; - procedure for staff to notify the RN (or appropriate Licensed Health Professional) when there is a problem with any medication management services; and - any resident-specific requirements relating to documentation of medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. Time period for correction: Seven (7) days	01730		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet	01760		

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01760	Continued From page 71 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 transcribe provider orders timely, ensure medications were administered per providers orders, and follow the process of medication administration for two of three residents (R2, R8) 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: MEDICATIONS NOT ADMINISTERED AS ORDERED/MEDICATION ERROR R2 R2's diagnoses included a history of falls, dependence on supplemental oxygen and long-term use of anticoagulants. R2's Service Plan dated October 5, 2021, indicated R2 received medication management services. R2's EMAR dated February 2022, included the following medications: one diuretic, one blood	01760		

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01760	Continued From page 72	01760		

sugar controlling medication, two blood pressure reducers, one stomach acid reducer, one diabetic medication, one bone loss preventative, two vitamin supplements, one anti-inflammatory, and two inhalers. Additionally, R2 was transferred back to licensee from a transition care unit (TCU) on February 24, 2022, with physician orders to begin an albuterol inhalant solution 0.5-2.5 (3) milligrams (mg)/ (3) millimeters (ml) to be administered four times daily. The EMAR was not updated to reflect the new order.

On March 1, 2022, at approximately 9:17 a.m., the surveyor observed unlicensed personnel (ULP)-B provide medication administration services to R2.

On March 1, 2022, at approximately 11:00 a.m., registered nurse (RN)-A confirmed R2's physician orders from February 24, 2022, for Ipratropium-Albuterol solution were not transcribed into R2's EMAR for administration until the morning of March 1, 2022, and staff did not administer R2's prescribed medications as ordered.

R8
R8 has diagnoses of dementia, retinopathy (blood vessels in eye are damaged), macular degeneration (vision impairment from deterioration of the central part of retina), chronic kidney disease (CKD).

R8's Memory Care Service Plan dated November 23, 2020, indicated R8 received services for 24/7 home health aide assistance, weekly medication reminders and assists, laundry services, linen changes, meals, activities specially programmed for individuals with dementia-related illness and medication management.

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01760	Continued From page 73 R8's EMAR dated February 2022, included the following medications for morning medication pass: acetaminophen 1000 mg, aspirin chewable 81 mg, preservision areds 2 chewable tablets, Refresh Tears one drop to each eye, memantine hcl 10mg, Benefiber 1 teaspoon (tsp), timolol maleate 0.5 percent (%) one drop both eyes, brimonidine tartrate 2% one drop both eyes, and sennoside syrup 8.8mg/ 5ml. On March 2, 2022, at approximately 7:51 a.m., the surveyor observed ULP-G provide medication administration services to R8. R8 did not receive timolol maleate 0.5 % one drop to each eye, brimonidine tartrate 2% one drop to each eye. Directly following the above medication pass observation, ULP-G confirmed she did not administer R8's prescribed medication as ordered. In addition, ULP-G stated she had never administered timolol maleate 0.5% and brimonidine tartrate 2% eye drops in the morning. The licensee's Requesting and Receiving Medication Prescriptions and Refills policy dated February 19, 2021, indicated the RN would make any changes to the EMAR immediately after receiving a prescription for a change in medication or a new medication. Licensee's Training Unlicensed Personnel for Medication Administration policy dated February 19, 2021, indicated the RN must instruct unlicensed personnel on performing delegated tasks and determine unlicensed personnel as competent to perform delegated tasks. PROCESS OF MEDICATION ADMINISTRATION	01760		

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01760	Continued From page 74 ULP-B ULP-B documented R2's medications as being administered prior to the medications being administered. On March 1, 2022, at approximately 9:17 a.m., the surveyor observed the following process used for medication administration: - ULP-B removed from the locked medication bin R2's scheduled morning medications and removed each from the sealed packages, placed the medications into a medication cup and counted the medications in the cup; - ULP-B reviewed the MAR on an iPad and marked each medication as administered on R2's MAR; - ULP-B then approached R2 who was seated at her table and completed the medication pass. Directly following the above medication pass observation, ULP-B verified he had documented R2's medications as being administered prior to the medications actually being administered. On March 1, 2022, at approximately 11:00 a.m., RN-A confirmed ULP-B did not administer R2's prescribed medications as ordered. ULP-G ULP-G set up R8's medications in advance of the administration time and incorrectly documented into R8's EMAR after medication administration. R8's EMAR dated February 2022, included the following medications for morning medication pass: acetaminophen 1000 mg, aspirin chewable 81 mg, preservision areds 2 chewable tablets, Refresh Tears one drop to each eye, memantine hcl 10mg, Benefiber 1 tsp, timolol maleate 0.5 % one drop to each eye, brimonidine tartrate 2%	01760		

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01760	Continued From page 75 one drop to each eye, and sennoside syrup 8.8mg/ 5ml. During a medication pass observation for R8 with ULP-G on March 2, 2022, at approximately 7:51 a.m., the surveyor observed the following: - ULP-G crushed morning medications that were tablets; - ULP-G combined crushed tablets with Benefiber, sennoside syrup and placed them into a glass of milk; - ULP-G placed medication cup into unlocked refrigerator; - ULP-G administered Refresh Tears with proper technique into R8's eyes; - ULP-G documented in EMAR that brimonidine tartrate 2% was administered and medications listed above were administered. Directly following the above medication pass observation, ULP-G acknowledged they documented Refresh Tears incorrectly on EMAR. In addition, ULP-G stated she did not know she could not set up medications in advance and place it in unlocked refrigerator for R8's husband to give later. On March 2, 2022, at approximately 8:17a.m., RN-A stated ULP's are not allowed to set up medication for family members to administer. In addition, medications must stay secured until administered to residents. The licensee's Training Unlicensed Personnel for Medication Administration policy dated February 19, 2021, indicated the RN must instruct unlicensed personnel on performing delegated tasks and determine unlicensed personnel as competent to perform delegated tasks.	01760		

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01760	Continued From page 76 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescription medications were stored according to the manufacturer's directions. 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: On February 28, 2022, at approximately 12:45 p.m., in the presence of the interim licensed assisted living director (ILALD)-C and registered nurse (RN)-A, the surveyor observed the unlocked medication refrigerator in the nurse's office. The Refrigerator Temperature Log, posted on the door of the medication refrigerator, dated	01880		

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01880	Continued From page 77 from January 20, 2022, to February 28, 2022, included documentation of temperatures that ranged from 47 degrees Fahrenheit (F) to 50 degrees F. The refrigerator temperatures were only recorded on 18 of the 40 days of opportunity. The medication refrigerator contained the following medications: - ten (10) Bisacodyl 10 mg (milligram) rectal suppositories for R10; - two (2) Bisacodyl 10 mg rectal suppositories for R11; - ten (10) Bisacodyl 10 mg rectal suppositories for R12; - fourteen (14) unopened Lantus Solo Star insulin pens (a multiple dose pen shaped injector device for insulin administration), three (3) unopened Novolog Flex insulin Pens, and two (2) unopened Victoza injectable pens for R13; - fifteen (15) unopened Lantus Solo Star Pens for R14; and - two (2) Enoxaparin sodium injectables (blood thinning medication) for R15. On February 28, 2022, at approximately 1:00 p.m., RN-A confirmed the medication refrigerator was unlocked, the temperatures were not recorded daily, and the refrigerator temperatures ranged from 47 degrees F to 50 degrees F. RN-A stated if the medication refrigerator temperatures were above 46 degrees F, the staff were to turn the temperature in the refrigerator down, and if the temperature did not go down, they were to report it to the nurse manager. On February 28, 2022, at approximately 1:15 p.m., in the presence of the ILALD-C, the surveyor observed the unlocked medication cupboard in the memory care unit.	01880		

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01880	Continued From page 78 The unlocked medication cupboard contained the following medications: - one (1) bottle of Tums (anti acid), one (1) bottle of liquid acetaminophen (for pain) and two (2) bottles of Good Sense 17-gram powder laxative; and two (2) box of lidocaine pain patches for R8; and - two (2) bottles of Goodsense 17-gram powder laxative and one (1) bottle of Senna (stool softener) syrup for R9. On February 28, 2022, at approximately 1:20 p.m., ILALD-C confirmed the medication cupboard on the memory care unit was unlocked and contained above mentioned medications. FDA (Food and Drug Administration) storage requirements for Bisacodyl rectal suppositories dated November 23, 2020, indicated Bisacodyl rectal suppositories should be stored at room temperature between 58 degrees to 86 degrees Fahrenheit. FDA storage requirements for Lantus Solo Star dated May 2019, indicated if unopened store at 36 degrees F to 46 degrees F in the refrigerator. Do not Freeze. FDA storage requirements for Novolog Flex Pens dated February 2015, indicated if unopened store at 36 degrees F to 46 degrees F in the refrigerator. Do not Freeze. FDA storage requirements for Victoza dated August 2017, indicated if unopened store at 36 degrees F to 46 degrees F in the refrigerator. Do not Freeze. FDA storage requirements for Enoxaparin sodium injectables dated October 2017, indicated to store	01880		

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01880	Continued From page 79 between 59 degrees F to 86 degrees F. The licensee's Storage of Medication policy dated February 1, 2021, indicated when a resident has medication(s), the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure time sensitive medication were labeled with the date opened or to dispose of expired medications. In addition. the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for two of four residents (R2, R8) 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	01890		

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01890	Continued From page 80	01890		

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:

On February 28, 2022, at approximately 11:26 a.m., executive director (ED)-D stated licensee provided medication management services for residents who received services. Interim licensed assisted living director (ILALD)-C stated medications were kept in resident rooms in locked boxes.

R2
R2's Trelegy Ellipta Aerosol Powder Breath Activated 100-62.5-25 microgram (mcg) inhalers lacked original prescription label and labels to indicate the date staff removed the inhalers from the pouch and when the inhalers would expire.

The manufacturer's instructions for the use of the Trelegy Ellipta inhaler dated June 2020, directed for the inhaler to be discarded six weeks after it had been opened from the foil tray. The tray opened and discard dates should be written on the inhaler label.

On March 1, 2022, at approximately 9:43 a.m., registered nurse (RN)-A confirmed all medications should have original labels and the above noted time sensitive medications should be dated after opening with an open date and expiration date.

R8
R8's Nystatin 100,000 units/gram bottle had an

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01890	Continued From page 81 expiration date of February 17, 2022. In addition, R8's timolol maleate 0.5 percent (%), brimonidine tartrate 2%, Refresh Tears was opened and lacked a label of when the eye drops would expire. On March 2, 2022, at approximately 7:51 a.m., ULP-G acknowledged Nystatin 100,000 units/gram bottle was expired. ULP-G also acknowledged timolol maleate 0.5 %, brimonidine tartrate 2%, Refresh Tears were opened and did not have a label of date opened. The manufacturer's instructions for the use of the Refresh Tear dated June 2016, and timolol maleate dated October 2019, directed for the eye drops to be discarded 30 days after opening. The Manufacturer's instructions for the use of brimonidine tartrate dated October 2020, directed for the eye drop to be discarded 28 days after opening. The licensee's Storage of Medication policy dated February 19, 2021, indicated medication should be kept in its original container bearing the original prescription label with legible information. A policy was requested regarding labeling and dating medications but was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or	01910		

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01910	Continued From page 82 medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R4) with record 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).	01910		

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01910	Continued From page 83 The findings include: R4's service plan dated February 18, 2021, indicated R4 received services for housekeeping, assessments, bathing and medication management. R4's unsigned physician orders dated October 20, 2021, included the following medications: acetaminophen 1000 milligrams (mg), aspirin delayed release 81mg, Crestor 10mg, Lovenox 40mg/0.4 milliliter (ml), omeprazole delayed release 20mg, oxycodone 2.5 mg, oxycodone 5mg, Seroquel 6.25mg and Zestril 40mg. R4's record lacked evidence of documentation of R4's disposition of medications to include name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On March 1, 2022, at 12:20 p.m., registered nurse (RN)-A confirmed R4's record lacked a medication disposition. RN-A stated they had sent all medications to the care center, (attached facility, seperately licensed) and they did not know it was needed when residents transferred to the care center. The licensee's Content of Client Records dated February 18, 2021, indicated, when a resident transferred to another provider or the resident's services are terminated, a discharge summary would include: - the service termination notice, if applicable; - the client's status at the time of transfer or discharge; and - the disposition of any medications that the	01910		

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01910	Continued From page 84 agency controlled or stored. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any	01940		

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01940	Continued From page 85 changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individual treatment management plan to include all required content for one of one resident (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included a history of falls, dependence on supplemental oxygen and long-term use of anticoagulants. R2's Service Plan dated October 5, 2021, indicated R2 received services to include; medication management, safety checks, vital signs weekly, bathing, escorts, blood sugar checks, personal assistance and compression stocking assistance. On March 1, 2022, at approximately 9:17 a.m., the surveyor observed unlicensed personnel (ULP)-B provide medication administration, oxygen monitoring and compression stocking placement for R2. R2's discharge physician orders dated February	01940		

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01940	Continued From page 86 25, 2022, included supplemental oxygen, 3 liters per minute (LPM) via nasal cannula, compression stockings on in the morning, off at night and nebulizer treatments four (4) times daily. On March 1, 2022, at approximately 9:17 a.m., the surveyor observed ULP-B administer R2's scheduled morning medications. While in R2's room, the surveyor observed an oxygen concentrator that had a flow rate set at 6 lpm providing supplemental oxygen to R2 via nasal cannula. The surveyor asked ULP-B to verify the flow rate and ULP-B verified it was set at 6 lpm. The surveyor asked ULP-B how often the flow rate was checked by staff and what the flow rate should be set at. ULP-B stated he thought the oxygen flow rate was checked every shift. ULP-B stated R2 knew what to do with the oxygen concentrator. R2 stated, "I don't think it's working." On March 1, 2022, at approximately 9:25 a.m., the surveyor observed ULP-B assist R2 with placement of compression stockings. ULP-B was asked what he would watch for when applying or removing the compression stockings. ULP-B stated, "Swelling. If legs swell, I tell the nurses." R2's Treatment/Therapy Management Plan lacked the following content: - a statement of the types of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy	01940		

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01940	Continued From page 87 services; and - any resident-specific requirements relating to documenting of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On March 1, 2022, at approximately 9:43 a.m., registered nurse (RN)-A confirmed R2's record lacked a complete and accurate individualized treatment and therapy plan. The licensee's Treatment and Therapy Management Services policy dated February 22, 2022, indicated based on the nursing assessment the RN would develop and implement and individualized treatment and therapy management plan for each resident receiving any type of treatment or therapy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20141	A. BUILDING: _____ B. WING _____	03/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST THERESE RESIDENCE	8008 BASS LAKE ROAD NEW HOPE, MN 55428

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01960	Continued From page 88 to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure treatments or therapies were administered as prescribed, or to document the reason they were not provided to meet the resident's needs for one of one resident (R2) with supplemental oxygen monitoring managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included a history of falls, dependence on supplemental oxygen and long-term use of anticoagulants. R2's Service Plan dated October 5, 2021, indicated R2 received services to include; medication management, safety checks, vital signs weekly, bathing, escorts, blood sugar checks, personal assistance, supplemental oxygen assistance and compression stocking assistance. On March 1, 2022, at approximately 9:17 a.m., the surveyor observed unlicensed personnel (ULP)-B provide medication administration, oxygen monitoring and compression stocking	01960		

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	20141	A. BUILDING: _____ B. WING _____	03/02/2022

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01960	Continued From page 89	01960		

placement for R2.

R2's discharge physician orders dated February 25, 2022, included supplemental oxygen, 3 liters per minute (LPM) via nasal cannula, compression stockings on in the morning, off at night and nebulizer treatments four (4) times daily.

On March 1, 2022, at approximately 9:17 a.m., the surveyor observed ULP-B administer R2's scheduled morning medications. While in R2's room, the surveyor observed an oxygen concentrator set at a flow rate of 6 lpm providing supplemental oxygen to R2 via nasal cannula. The surveyor asked ULP-B to verify the flow rate and ULP-B verified it was set at 6 lpm. The surveyor asked ULP-B how often the flow rate was checked by staff and at what the flow rate should be set. ULP-B stated he thought the oxygen flow rate was checked every shift. ULP-B stated R2 knew what to do with the oxygen concentrator. R2 stated, "I don't think it's working."

On March 1, 2022, at approximately 9:36 a.m., registered nurse (RN)-A confirmed R2's supplemental oxygen was not set at 3 lpm as ordered and was set at 6 lpm. RN-A stated, "I will reach out to the doctor for new orders." Additionally, RN-A confirmed ULP-B had documented administration of the nebulizer treatment and confirmed the nebulizer was not administered.

The licensee's Administration of Treatment or Therapy by Unlicensed Personnel policy dated March 1, 2021, indicated When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any

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01960	Continued From page 90 follow-up procedures that were provided to meet the resident's needs. Additionally, the policy indicated a nurse would periodically review the treatment or therapy being administered by unlicensed professional to ensure the treatment or therapy is being completed as prescribed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	02040		

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	20141	A. BUILDING: _____ B. WING _____	03/02/2022

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02040	Continued From page 91 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 residents). The findings include: Survey staff requested a facility hazard vulnerability or safety risk assessment documentation, but the licensee did not provide the requested documentation. During the interview on February 28, 2022, at 3:10 p.m., the plant operations director (POD)-E stated they did not have the documentation I was requesting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=D	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 a suitable and up-to-date plan, and subject to accepted health care and medical, or nursing standards for two of three residents (R1, R2) with records	02310		

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02310	Continued From page 92 reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee failed to ensure oxygen cylinders were secured in a rack to prevent tipping or damage. R1 R1's diagnoses included COPD (chronic obstructive pulmonary disease). R1's record indicated R1 used oxygen at three (3) liters per minute (LPM) via nasal cannula. On March 1, 2022, at approximately 12:11 p.m., the surveyor and registered nurse (RN)-A observed an oxygen cylinder standing in R1's living room and one oxygen cylinder in R1's bed room that were not in a secured container. On March 1, 2022, at approximately 12:11 p.m., RN-A confirmed the oxygen cylinders were not stored in a secured container. R2 R2's diagnoses included a history of falls, dependence on supplemental oxygen and long-term use of anticoagulants.	02310		

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02310	Continued From page 93 R2's record indicated R2 used oxygen at three (3) LPM via nasal cannula. On March 1, 2022, at approximately 9:43 a.m., the surveyor and RN-A observed five oxygen cylinders lined up against R2's bedroom wall. All five oxygen cylinders were unsecured. On March 1, 2022, at approximately 9:46 a.m., RN-A confirmed the oxygen cylinders were not stored in a secured rack. The licensee's Safe Oxygen Use and Storage policy dated March 1, 2021, indicated oxygen containers must be secured in a stand so they cannot be knocked over while in use or in storage and must not be located in areas where they may be overturned due to a door opening. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	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:	03090		

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03090	Continued From page 94 Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 28, 2022, at approximately 11:25 a.m., upon entering the facility, the surveyor observed no electronic monitoring notice posted in the facility with the statutory required language. On February 28, 2022, at approximately 12:33 p.m., interim licensed assisted living director (ILALD)-C acknowledge the licensee failed to post the required electronic monitoring notice. ILALD-C indicated the sign was accidently removed when they were taking down other signs, and they would post signs again. The licensee lacked policy and procedure related to electronic monitoring. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *02/28/22*
Time: 13:00:00
Report: 8087221047

Food and Beverage Establishment Inspection Report

Location:
St Therese Residence
8008 Bass Lake Road
New Hope, MN55428
Hennepin County, 27

Establishment Info:
ID #: 0038861
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635315400
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = -- at 192 Degrees Fahrenheit
Location: 3-COMPARTMENT SINK
Violation Issued: No

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: WALL DISPENSING UNIT
Violation Issued: No

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Wash Temperature Gauge: = -- at 161 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Rinse Temperature Gauge: = -- at 180 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Max Utensil Surface Temp: = -- at 161 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: -1 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 33 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: GROUND BEEF
Temperature: 33 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 33 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: COOKED PASTA
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: SOUP
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 38 Degrees Fahrenheit - Location: MIDDLE COOLER
Violation Issued: No

Process/Item: Cold Holding: EGG SALAD
Temperature: 38 Degrees Fahrenheit - Location: MIDDLE COOLER
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 38 Degrees Fahrenheit - Location: MIDDLE COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 38 Degrees Fahrenheit - Location: MIDDLE COOLER
Violation Issued: No

Process/Item: Cooking: SOUP
Temperature: 179 Degrees Fahrenheit - Location: STOVE TOP - FOR HOT HOLDING
Violation Issued: No

Process/Item: Ambient Air
Temperature: 34 Degrees Fahrenheit - Location: FRONT COOLER
Violation Issued: No

Process/Item: Cold Holding: POTATO SALAD
Temperature: 38 Degrees Fahrenheit - Location: FRONT COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding: WHIP CREAM
Temperature: 40 Degrees Fahrenheit - Location: FRONT COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 40 Degrees Fahrenheit - Location: FRONT COOLER
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION DONE WITH DIRECTOR GREGORY P. HEIGEL.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO HRD NURSE EVALUATOR ASHLEY CREWS.

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 8087221047 of 02/28/22.

Certified Food Protection Manager GREGORY P. HEIGEL

Certification Number: FM77724 Expires: 03/27/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
GREGORY P. HEIGEL
DIRECTOR

Signed: _____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us