Electronically Delivered

April 28, 2022

Administrator
River Oaks at Lake Pepin LLC
815 North High Street
Lake City, MN 55041

RE: Project Number(s) SL31884015

Dear Administrator:

On April 12, 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 December 9, 2021. The follow-up evaluation determined your agency had corrected all of the state licensing orders issued pursuant to the December 9, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on December 9, 2021, found not corrected at the time of the April 12, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) - $500.00

The details of the violations noted at the time of this follow-up evaluation completed on April 12, 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 $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

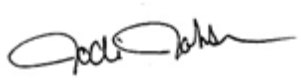
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 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 Jodi Johnson, Supervisor, at 507-344-2730 .

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,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31884	A. BUILDING: _____ B. WING _____	R 04/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT LAKE PEPIN LLC	815 NORTH HIGH STREET LAKE CITY, MN 55041

(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: Project # SL31884015 On April 12, 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 February 24, 2022 and December 9, 2021. 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.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 12, 2022, for the specific Minnesota Food Code deficiencies.	{0 480}		

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{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control 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: No further action required.	{0 660}		
{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: No further action required	{0 800}		

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{0 810}	Continued From page 3	{0 810}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at 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: No further action required	{0 810}		

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{01370} SS=E	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all 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	{01370}		

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{01370}	Continued From page 5 technology equipment and assistive devices. This MN Requirement is not met as evidenced by: No further action required	{01370}		
{01490} SS=D	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: No further action required.	{01490}		
{01730} SS=D	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;	{01730}		

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{01730}	Continued From page 6 (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: No further action required.	{01730}		
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special	{01790}		

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{01790}	Continued From page 7	{01790}		

instructions for administering or handling the medications, including controlled substances; and
(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.
(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:
(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and
(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:
(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;
(ii) how the container or containers must be labeled;
(iii) written information about the medications to be provided;
(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;
(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the

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{01790}	Continued From page 8 designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: No further action required.	{01790}		
{01940} SS=E	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	{01940}		

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{01940}	Continued From page 9 (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: No further action required.	{01940}		
{01950} SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	{01950}		

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{01950}	Continued From page 10 This MN Requirement is not met as evidenced by: No further action required.	{01950}		
{02260} SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: No further action required.	{02260}		

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul
651-201-4500

Type: Follow-Up
Date: *04/12/22*
Time: 11:55:51
Report: 7962221081

Food and Beverage Establishment Inspection Report

Location:
River Oaks At Lake Pepin Llc
815 North High Street
Lake City, MN55041
Wabasha County, 79

Establishment Info:
ID #: 0038182
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513452713
ID #:

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

The following orders previously issued between 12/07/21 and 02/23/22 have NOT been corrected.

5-200B Plumbing: cross connections

5-203.14 ** Priority 1 **

MN Rule 4626.1085A Backflow prevention devices must be installed in accordance with chapter 4714.

GARBAGE DISPOSAL DOES NOT HAVE BACKFLOW DISCUSSED WITH FSD(E)

2-23-22 REISSUED WORK WITH A PLUMBER CERTIFIED IN BACKFLOW PREVENTION FOR MOP SINK CHEMICAL CONNECTION AND GARBAGE DISPOSAL

4-12-22 REISSUED SENT DIAGRAM TO MAINTENANCE

Issued on: 12/07/21 *Comply By: 12/07/21*

4-500 Equipment Maintenance and Operation

4-501.114A ** Priority 1 **

MN Rule 4626.0805A Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.

WAREWASHING MACHINE 0PPM, CORRECTED TO 50PPM DURING INSPECTION

4-12-22 DISH MACHINE 0 PPM WILL USE DISH MACHINE FOR WASHING THEN TRANSFER WASHED DISHES TO A CONTAINER OF SANITIZER

Issued on: 02/23/22 *Comply By: 02/23/22*

4-200 Equipment Design and Construction

4-204.117B ** Priority 2 **

MN Rule 4626.0643B Provide a visual or audible signal on the warewashing machine to alert user when detergent and sanitizer are not being delivered during the respective cycles.

NO ALARM ON WAREWASHING MACHINE, CHLORINE SANITIZER 0PPM

4-12-22 REISSUED NEW MACHINE TO BE DELIVERED IN 22 WEEKS

Issued on: 02/23/22 *Comply By: 02/23/22*

8-200 Plan Submission and Approval

8-201.11B ** Priority 2 **

MN Rule 4626.1720B Submit complete plans and specifications to the regulatory authority for review and approval at least 30 days prior to beginning any new construction, conversion, change of type of food establishment or food operation, or extensive remodeling of a food establishment.

PLAN REVIEW MAY BE REQUIRED FOR HOOD INSTALLATION

4-12-22 REISSUED, NEW DISH MACHINE

Issued on: 02/23/22 *Comply By: 02/23/22*

4-200 Equipment Design and Construction

4-201.11BMN

MN Rule 4626.0506B Provide an exhaust ventilation hood that meets the requirements in the Minnesota Mechanical Code, Minnesota Rules, chapter 1346.

NO HOOD OVER OVEN, PLAN REVIEW MAY BE REQUIRED, CONTACT HRD INSPECTOR BEFORE MAKING CHANGES, WORK WITH MECHANICAL ENGINEER FOR ASSISTANCE

4-12-22 PLAN: NEW OVEN, REMOVE GRIDDLE, MECHANICAL ENGINEER MUST PROVIDE DOCUMENTATION OF COMPLIANCE

Issued on: 02/23/22 *Comply By: 02/23/22*

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

MISSING CEILING TILES IN DISH MACHINE ROOM

4-12-22 REISSUED WILL COMPLETE WHEN NEW DISH MACHINE IS INSTALLED

Issued on: 02/23/22 *Comply By: 02/23/22*

Food and Beverage Establishment Inspection Report

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 50 ppm at Degrees Fahrenheit
Location: 0PPM DISH WASHING MACHINE, WILL USE DISH MACHINE FOR WASHING THEN TRANSFER WASHED DISHES TO A CONTAINER OF SANITIZER. NEW MACHINE TO BE DELIVERED IN 22 WEEKS
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Display Cooler
Temperature: 41 Degrees Fahrenheit - Location: SELF SERVE DISPLAY COOLER
Violation Issued: No

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

Establishment Info:

4-12-22 report emailed to HRD Nurse Evauluator, Danette Bakken and FPLS Supervisor Matt Finkenbiner

12-21-21 report emailed to HRD Nurse Evauluator, Danette Bakken and FPLS Supervisor Matt Finkenbiner

12-7-2021 food service inspection report emailed to HRD Nurse Evauluator, Danette Bakken danette.bakken@state.mn.us

Sent with report:
- Backflow fact sheet for mop sink faucet; faucet does not have backflow protection and is directly connected to a chemical dispenser
- Vomit poster for kitchen; Food Service Director to put near mop sink
- Equipment fact sheet; 2nd page discusses adult care centers
- Temperature Controlled for Safety fact sheet
- Department of Labor and Industry backflow responsibility fact sheet
- Pictures from todays inspection

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 7962221081 of 04/12/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Kabrie Miller
Dietary Manager

Signed:_____
Heather Flueger
Public Health Sanitarian
Rochester District Office
507-208-3096
heather.flueger@state.mn.us

Electronically delivered

March 23, 2022

Administrator
River Oaks At Lake Pepin, LLC
815 North High Street
Lake City, MN 55041

RE: Project Number(s) SL31884015

Dear Administrator:

On February 24, 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 December 9, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the December 9, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on December 9, 2021, found not corrected at the time of the February 24, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0480-Minimum Requirements-144g.41 Subd 1 (13) (i) (b) = $500.00
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 = $500.00
1790-Medication Management For Residents Who Will-144g.71 Subd. 10 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on February 24, 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 Jodi Johnson at 507-344-2730.

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,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 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
	31884	A. BUILDING: _____ B. WING _____	R 02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT LAKE PEPIN LLC	815 NORTH HIGH STREET LAKE CITY, MN 55041

(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: Project # SL31884015 On February 23, 2022 through February 24, 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 December 9, 2021. At the time of the survey, there were 35 residents receiving services under the Assisted Living 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.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 23, 2022, for the specific Minnesota Food Code deficiencies.	{0 480}		

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{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC). This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	{0 660}		

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{0 660}	Continued From page 3 The findings include: The licensee lacked a written TB infection control plan for the procedures to address early recognition and isolation with suspected or confirmed active TB; therefore, none of the licensee's employees had received training on their role in the procedure. The licensee's policy TB Prevention and Control dated August 1, 2021, indicated "If a case of suspected or confirmed TB disease is identified among staff or clients, we assure that appropriate actions will be taken immediately which will include early recognition, isolation of the client or staff member and we will refer the client/staff to an appropriate medical facility. We will assist with arrangements for transfer of the client/staff member to an inpatient facility while collaborating and cooperating with local public health and MDH [Minnesota Department of Health]. RN or designee will educate the staff on the plan." The policy also indicated the clinical nurse supervisor or RN was responsible for establishing and maintaining the TB prevention and control program and responsibilities included, but not limited to, education of assisted living staff regarding TB signs and symptoms, our infection control plan, and other communicable diseases; however, the policy did not address all of the licensee's health care worker's (HCW's) role in their facility's TB infection control program and did not specify the procedure to be taken for "isolation of the client." The policy also indicated the licensee would establish and maintain a TB prevention and control program based on the most current guidelines issued by the CDC and the MDH guidelines Regulations for TB control in	{0 660}		

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{0 660}	Continued From page 4 Minnesota Health Care Settings would be followed. Unlicensed personnel (ULP)-F, ULP-G and ULP-M's records lacked evidence of documented education for the licensee's TB plan. The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: written TB infection control procedures. Procedures should address: Early recognition: All HCW's should know the signs and symptoms of TB and their role in their facility's TB infection control program. Isolation: Place a potentially infectious TB patient in an airborne infection isolation (AII) room if available; If not, place patient in separate room with door shut. On February 24, 2022, at 10:59 a.m. registered nurse (RN)-C and RN-D verified the licensee's policy lacked clear written procedures to address early recognition and isolation for handling residents with suspected or confirmed active TB. RN-C and RN-D also verified employees had not been educated on the licensee's TB plan. No further information was provided.	{0 660}		
{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	{0 800}		

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{0 800}	Continued From page 5 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action is required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at 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	{0 810}		

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{0 810}	Continued From page 6 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: No further action is required.	{0 810}		
{01370} SS=E	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all 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	{01370}		

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{01370}	Continued From page 7 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: Based on interview and record review, the licensee failed to ensure training and competency evaluations contained all the required training for three of three unlicensed personnel (ULP-F, ULP-G, ULP-M) 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: ULP-F had a hire date of November 15, 2021, ULP-G had a hire date of July 15, 2021, and ULP-M had a hire date of October 11, 2021. ULP-F, ULP-G, and ULP-M's records lacked evidence of training for medication, exercise and treatment reminders.	{01370}		

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{01370}	Continued From page 8 On February 24, 2022, at 10:59 a.m. registered nurse (RN)-C and RN-D verified ULP-F, ULP-G and ULP-M lacked training for medication, exercise and treatment reminders. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated unlicensed personnel that will provide assistance with medication, treatment and therapy administration would be trained and competency tested by the RN for, but not limited to, the complete procedures for checking the client's medication administration record and medication profile, treatment and therapy profile and any additional information and administration of the medication, treatment and therapy to the client (or assistance with self-administration). The RN may delegate to unlicensed personnel the task of providing assistance with self-administration of medications or may delegate administration of medications, treatment and therapy if the unlicensed personnel have satisfied the training requirements. Documentation of each unlicensed staff person's training and competency to assist or administer medications, treatment and therapy will be retained in the personnel record of each staff person who has satisfied the above training and competency requirements. No further information was provided.	{01370}		
{01490} SS=D	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section	{01490}		

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{01490}	Continued From page 9 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training for dementia care was completed as required for two of two unlicensed personnel (ULP-G, ULP-M) 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-G ULP-G had a hire date of July 15, 2021. ULP-G's record identified training for dementia completed on July 19, 2021, included the following: activities (a balanced approach), communication overview, dementia overview, person centered care, problem solving overview and the face of dementia (the journey) for a total of 5.25 hours. ULP-G's record lacked evidence of receiving at least eight hours total for dementia training within of a total 160 working hours as required. ULP-M ULP-M had a hire date of October 11, 2021.	{01490}		

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{01490}	Continued From page 10 ULP-M's record identified training for dementia completed on October 12, 2021, included the following: activities (a balanced approach), communication overview, dementia overview, person centered care, problem solving overview and the face of dementia (the journey) for a total of 5.25 hours. ULP-M's record lacked evidence of receiving at least eight hours total for dementia training within of a total 160 working hours as required. On February 24, 2022, at 1:00 p.m. RN-C confirmed ULP-G and ULP-M lacked the above training. The licensee's Assisted Living Dementia Training policy dated August 1, 2021, indicated direct care staff would complete a minimum of eight hours of initial training on dementia care topics within 160 working hours of the employment start date and the training would include the topics of an explanation of Alzheimer's disease and other dementia's, assistance with activities of daily living, problem solving with challenging behaviors, communication skills and person-centered planning and service delivery. No further information provided.	{01490}		
{01730} SS=D	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	{01730}		

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RIVER OAKS AT LAKE PEPIN LLC	815 NORTH HIGH STREET LAKE CITY, MN 55041

(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
{01730}	Continued From page 11 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. (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 interview and record review, the	{01730}		

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{01730}	Continued From page 12	{01730}		

licensee failed to ensure an individualized medication management plan included all the required content for one of four residents (R10) 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:

R10's record lacked evidence of documentation of specific resident instructions relating to the administration of as needed (PRN) medications.

R10's Individual Medication Management Plan dated January 25, 2022, indicated documentation of specific resident instructions relating to administration of medications was located on the resident's medication administration record (MAR).

R10's MAR dated February 9, 2022, to February 23, 2022, included acetaminophen (used for pain) 500 milligrams (mg) give two tablets every six hours PRN for pain, Dilaudid (used for pain) 2 mg give one tablet every four hours PRN for pain, prochlorperazine (used for nausea) 10 mg every six hours PRN nausea/vomiting, Zofran (used for nausea) 8 mg one tablet every eight hours PRN for nausea/vomiting, Loxapine (used to treat schizophrenia) 10 mg give 20 mg once daily PRN, hydroxyzine (used for treatment of anxiety) 50 mg one tablet every four hours PRN for

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{01730}	Continued From page 13 anxiety and lorazepam (used for anxiety) 0.5 mg one tablet three times daily PRN for nausea. R10's MAR lacked documentation of specific instructions for parameters for as needed (PRN) medications used for pain, nausea and anxiety (which to administer first). On February 24, 2022, at 1:00 p.m. registered nurse (RN)-C verified R10's record lacked evidence of documentation of specific instructions for parameters for PRN medications used for pain, nausea and anxiety. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated the RN may delegate to unlicensed personnel the task of providing assistance with self-administration of medications or may delegate administration of medications if the unlicensed personnel had satisfied the training requirements and the RN had developed written, specific instruction for each client. No further information provided.	{01730}		
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the	{01790}		

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{01790}	Continued From page 14	{01790}		

medications, including controlled substances; and
(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.
(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:
(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and
(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:
(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;
(ii) how the container or containers must be labeled;
(iii) written information about the medications to be provided;
(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;
(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;

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{01790}	Continued From page 15 (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure three of three unlicensed personnel (ULP-F, ULP-G and ULP-M) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away 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: ULP-F had a hire date of November 15, 2021. ULP-G had a hire date of July 15, 2021. ULP-M had a hire date of October 11, 2021. ULP-F and ULP-G's records included documented "Training Record" for "Resident LOA	{01790}		

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{01790}	Continued From page 16 [leave of absence] Policy and Procedure" dated January 26, 2022, and indicated registered nurse (RN)-C attested the staff members had successfully completed the training as described; however, an attendance sheet for a staff meeting held on January 26, 2022, at 1:00 p.m. was provided and indicated ULP-M had attended the training, but the attendance sheet failed to indicate what subject(s) were provided for training. The licensee lacked provision of documented evidence of training for ULP-M for "Resident LOA [leave of absence] Policy and Procedure." ULP-F, ULP-G and ULP-M's records lacked evidence to indicate the RN determined competency to prepare and administer medications to residents for unplanned times away. On February 24, 2022, at 1:00 p.m. RN-C stated she had provided training for "Resident LOA [leave of absence] Policy and Procedure," but had not conducted demonstrated competency with the licensee's ULP to prepare or give medications for any of the licensee's residents for unplanned times away. The licensee's Delegation of Medications to be Given to Clients by Unlicensed Staff for Clients Time Away from Home policy dated August 1, 2021, indicated only unlicensed staff that have been trained and have satisfactorily demonstrated competency would be assigned to place medications prepared by a pharmacist or a licensed nurse in the appropriate container for an unplanned leave of absence. No further information provided.	{01790}		

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

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{01940}	Continued From page 18 residents (R2, R8, R10) receiving treatments 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's Individualized Treatment and Therapy Management Plan dated January 25, 2022, included blood sugar checks three times daily. The plan further indicated records of treatments or therapy administration and specific instructions were maintained in the resident's permanent record and specific resident instructions relating to the treatments or therapy administration would be recorded on the resident's treatment or medication administration record (TAR/MAR). R2's Service Agreement dated January 26, 2022, indicated "blood glucose assistance" receives blood glucose checks three times a day with meals and as needed at bedtime. "Update nurse if he refuses" and "BIPAP [bilevel positive airway pressure] assist" assist in setting up BIPAP machine every evening. R2's MAR dated February 9, 2022, to February 23, 2022, indicated "Blood Sugars monitor blood sugars 3 times per day 15-20 minutes before he eats meals. Remind resident to remove needle and place in sharps container. Blood glucose	{01940}		

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{01940}	Continued From page 19	{01940}		

goal: 200 or less. Contact primary care provider if consistently out of goal range" and "CPAP [continuous positive airway pressure] care in P.M./Cleaning" put BIPAP components back together every evening and remind to wear when he goes to bed/wash CPAP tubing and components in warm soapy water daily. Hang tubing over shower to dry.

R2's Individualized Treatment and Therapy Management Plan failed to address:
-procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services

On February 24, 2022, at 1:00 p.m. registered nurse (RN)-C verified R2's record lacked evidence of procedures for notifying a registered nurse for the treatments or therapy services for blood sugar checks and BIPAP.

R8
R8's Individualized Treatment and Therapy Management Plan dated January 25, 2022, included blood sugar checks four times daily, hand splint daily and compression wraps daily. The plan further indicated records of treatments or therapy administration and specific instructions were maintained in the resident's permanent record and specific resident instructions relating to the treatments or therapy administration would be recorded on the resident's TAR/MAR.

R8's Service Agreement dated January 25, 2022, indicated "blood glucose assistance" assist with checking blood sugar before meals per provider orders and document "EMAR" (electronic MAR) receives blood glucose checks three times a day with meals and as needed at bedtime/blood sugar

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{01940}	Continued From page 20	{01940}		

monitoring three times daily assist as needed and "other delegated tasks" assist with application of splint every day.

R8's Physician Order Sheet dated February 2, 2022, included orders for compression daily both lower legs-apply knee high cotton sock-start compression application at the base of toes-apply two low stretch wraps in a spiral fashion-stop compression right below the knee-keep on until returning to bed or elevating legs for the night, apply TENS unit (a method of pain relief involving the use of a mild electrical current) sticky pads tor resident's shoulder/neck area as needed (PRN) for pain, assist resident with hand splint bedtime-place left hand on blue sling-place thumb on outside lip of sling, blood sugar check four times a day before meals and at bedtime using resident's Freestyle Libre device- power device on- hold up to sensor on back of arm-record reading-if "lo" or "Hi" shows on display, check with finger poke, apply/remove edema glove (compression)-remove edema glove from left hand two hours before sleep-edema glove should be worn on left hand and apply/remove TED stockings (compression) in the morning and remove, wash out and hang to dry in the evening-apply is refusing compression wraps-only to be used if compression wraps are refused PRN.

R8's MAR dated February 8, 2022, to March 7, 2022, indicated "Remove Compression Wrap" indicate if compression stockings were removed and time, "Compression" both lower legs: apply knee high cotton sock-start compression application at the base of toes-apply two low stretch wraps in a spiral fashion-stop compression right below the knee-keep on until returning to bed or elevating legs for the night,

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{01940}	Continued From page 21 "Blood Sugar" check blood sugar before meals and at bedtime using resident's Freestyle Libre device-power device on-hold up to sensor on back of arm-record reading-if "lo" or "Hi" shows on display, check with finger poke-if sensor reading results in magnifying glass and drop of blood use glucometer to do a finger poke blood sugar reading, "Assist Resident with Hand Splint" assist with removal of left hand splint-observe residents hand foe redness-report to nursing staff-place left hand on blue sling-place thumb on outside lip of sling-put strap over thumb, wrist and lower arm, "Apply Tens Unit" apply TENS unit sticky pads to resident's shoulder/neck area PRN, "Apply/Remove Edema Glove" remove edema glove form left hand two hours before sleep-edema glove should be worn on left hand and "Apply/Remove TED Stockings" apply TED stockings in the morning and remove, wash out and hang to dry in the evening-apply is refusing compression wraps-only to be used if compression wraps are refused PRN. R8's Individualized Treatment and Therapy Management Plan failed to address: - a statement of the type of services that would be provided; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; and - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services On February 24, 2022, at 1:00 p.m., RN-C verified R8's Individualized Treatment and Therapy Management Plan failed to include the treatments of cotton socks, TEDS, TENS unit and edema glove, including identification of task that would be delegated to unlicensed personnel.	{01940}		

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{01940}	Continued From page 22 RN-C verified R8's record lacked evidence of procedures for notifying a registered nurse for the treatments or therapy services for blood sugar checks, cotton socks, compression wraps, TEDS, TENS unit and edema glove. R10 R10's Individualized Treatment and Therapy Management Plan dated January 25, 2022, included blood sugar checks daily, port monitoring daily and CPAP daily. The plan further indicated records of treatments or therapy administration and specific instructions were maintained in the resident's permanent record and specific resident instructions relating to the treatments or therapy administration would be recorded on the resident's TAR/MAR. R10's Service Agreement dated January 25, 2022, indicated "CPAP Assist" wash out CPAP tubing and mask daily, "Other Delegated Task" monitor port site for signs and symptoms of infection such as redness, drainage, or fever, "blood glucose assistance" assist with checking blood glucose levels every morning at 7 a.m., "CPAP assist" put resident's CPAP tubing and mask back on machine and assure resident is wearing it every night while sleeping and "TED's Assist" apply TED stockings and knee sleeves or ACE wraps each day per provider's orders. Utilize essential oil pain blend prior to applying and remind resident the stockings will need to remain on until bedtime and cannot be pulled down for pain blend once they are on. R10's Physician Order Sheet dated February 1, 2022, included orders for blood sugar check daily before breakfast, CPAP cleaning and daily support stockings-place stockings on in the morning when she gets up and take off at	{01940}		

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{01940}	Continued From page 23	{01940}		

bedtime-remind once socks are on for the day they need to stay on until she is ready for bed-they should not be taken off and put back on at any time-this will cause swelling and make it difficult to get her socks back on.

R10's MAR dated February 9, 2022, to February 23, 2022, indicated "Blood Sugar" check blood sugar before breakfast-remind resident to remove needle and place in sharps, "CPAP Care in P.M." put CPAP components back together every evening and remind resident to wear when she goes to bed, "CPAP Cleaning" wash CPAP tubing and components in warm soapy water daily-hang tubing over shower to dry, "Support Stockings" place stockings on in the morning when she gets up and take off at bedtime-remind once socks are on for the day they need to stay on until she is ready for bed-they should not be taken off and put back on at any time-this will cause swelling and make it difficult to get her socks back on.

R10's Individualized Treatment and Therapy Management Plan failed to address:
- a statement of the type of services that would be provided;
- identification of treatment or therapy tasks that would be delegated to unlicensed personnel; and
- procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services

On February 24, 2022, at 1:00 p.m. RN-C verified R10's Individualized Treatment and Therapy Management Plan failed to include the treatments of TEDS, including identification of task that would be delegated to unlicensed personnel. RN-C verified R10's record lacked evidence of procedures for notifying a registered nurse for the

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{01940}	Continued From page 24 treatments or therapy services for blood sugar checks, CPAP and TEDS. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, indicated for delegation of medication related tasks a registered nurse may delegate medication administration to unlicensed personnel only after the RN had developed specific written instructions for each client and documented those instructions in the client's medication record/MAR. The policy did not address delegation of treatment or therapy tasks. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated the RN may delegate to unlicensed personnel the task of treatment and therapy if the RN had developed written, specific instruction for each client. The policy did not address identification of treatment or therapy tasks that would be delegated to unlicensed personnel and procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. No further information provided.	{01940}		
{01950} SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment	{01950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31884	A. BUILDING: _____ B. WING _____	R 02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT LAKE PEPIN LLC	815 NORTH HIGH STREET LAKE CITY, MN 55041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01950}	Continued From page 25	{01950}		

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

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure an the registered nurse (RN) had instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident (R2, R8, R10) and the ULP has demonstrated the ability to competently follow the procedures for three of three employees (ULP-F, ULP-G, ULP-M) 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's medication administration record (MAR)

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	31884	A. BUILDING: _____ B. WING _____	R 02/24/2022

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{01950}	Continued From page 26 dated February 9, 2022, to February 23, 2022, indicated "CPAP [continuous positive airway pressure] care in P.M./Cleaning" put BIPAP components back together every evening and remind to wear when he goes to bed/wash CPAP tubing and components in warm soapy water daily. Hang tubing over shower to dry. ULP-G ULP-G had a hire date of July 15, 2021. ULP-G's record included Training Record dated January 26, 2022, for training completed for BIPAP for R2, which included specific instructions for what BIPAP stands for, reasons used, settings for use and cleaning. The training record further indicated, "I attest that this staff member has successfully completed the training as described" and was signed by RN-C. ULP-G's record lacked demonstrated practical skills competency for providing the delegated task of BIPAP. ULP-M ULP-M had a hire date of October 11, 2021. ULP-M's record lacked training and demonstrated practical skills competency for providing the delegated task of BIPAP for R2. On February 24, 2022, at 1:00 p.m. RN-C verified ULP-G's record lacked evidence of demonstrated practical skills competency for providing the delegated task of BIPAP, and ULP-M's record lacked evidence of training and demonstrated practical skills competency for providing the delegated task of BIPAP for R2.	{01950}		

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{01950}	Continued From page 27 R8 R8's Physician Order Sheet dated February 2, 2022, included orders for compression daily both lower legs-apply knee high cotton sock-start compression application at the base of toes-apply two low stretch wraps in a spiral fashion-stop compression right below the knee-keep on until returning to bed or elevating legs for the night, apply TENS unit (a method of pain relief involving the use of a mild electrical current) sticky pads tor residents shoulder/neck area as needed (PRN) for pain, assist resident with hand splint bedtime-place left hand on blue sling-place thumb on outside lip of sling, blood sugar check four times a day before meals and at bedtime using resident's Freestyle Libre device- power device on- hold up to sensor on back of arm-record reading-if "lo" or "Hi" shows on display, check with finger poke, apply/remove edema glove-remove edema glove from left hand two hours before sleep-edema glove should be worn on left hand and apply/remove TED stockings (compression) in the morning and remove, wash out and hang to dry in the evening-apply is refusing compression wraps-only to be used if compression wraps are refused PRN. R8's MAR dated February 8, 2022, to March 7, 2022, indicated "Remove Compression Wrap" indicate if compression stockings were removed and time, "Compression" both lower legs: apply knee high cotton sock-start compression application at the base of toes-apply two low stretch wraps in a spiral fashion-stop compression right below the knee-keep on until returning to bed or elevating legs for the night, "Blood Sugar" check blood sugar before meals and at bedtime using resident's Freestyle Libre device-power device on-hold up to sensor on	{01950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31884	A. BUILDING: _____ B. WING _____	R 02/24/2022

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{01950}	Continued From page 28	{01950}		

back of arm-record reading-if "lo" or "Hi" shows on display, check with finger poke-if sensor reading results in magnifying glass and drop of blood use glucometer to do a finger poke blood sugar reading, "Assist Resident with Hand Splint" assist with removal of left hand splint-observe residents hand foe redness-report to nursing staff-place left hand on blue sling-place thumb on outside lip of sling-put strap over thumb, wrist and lower arm, "Apply Tens Unit" apply TENS unit sticky pads to residents shoulder/neck area PRN, "Apply/Remove Edema Glove" (compression) remove edema glove form left hand two hours before sleep-edema glove should be worn on left hand and "Apply/Remove TED Stockings" apply TED stockings in the morning and remove, wash out and hang to dry in the evening-apply is refusing compression wraps-only to be used if compression wraps are refused PRN.

ULP-F had a hire date of November 15, 2021.

ULP-F, ULP-G and ULP-M's records lacked evidence of training and competency for the treatment of hand splint, compression wraps, TENS unit, Freestyle Libre device and edema glove for R8.

On February 24, 2022, at 1:00 p.m. RN-C verified ULP-F, ULP-G and ULP-M's records lacked evidence of training and competency for the treatment of hand splint, compression wraps, TENS unit, Freestyle Libre device and edema glove for R8.

R10
R10's Physician Order Sheet dated February 1, 2022, included orders for CPAP (continuous positive airway pressure) cleaning.

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{01950}	Continued From page 29 R10's MAR dated February 9, 2022, to February 23, 2022, indicated "CPAP Care in P.M." put CPAP components back together every evening and remind resident to wear when she goes to bed and "CPAP Cleaning" wash CPAP tubing and components in warm soapy water daily-hang tubing over shower to dry. ULP-F, ULP-G and ULP-M's record lacked evidence of training and competency for the treatment of CPAP for R10. On February 24, 2022, at 1:00 p.m. RN-C verified ULP-F, ULP-G and ULP-M's records lacked evidence of training and competency for the treatment of CPAP for R10. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, indicated for delegation of nursing tasks the RN would develop a service plan for providing the services according to the resident's needs and preferences, verify the ULP is trained and competent and is instructed in the proper methods to perform the task with respect to the specific client; if the ULP is not trained, the RN will provide training in-person, verbally, or through other acceptable methods and the RN or other appropriately licensed staff will document any ULP training and/or competencies. No further information provided.	{01950}		
{02260} SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the	{02260}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{02260}	Continued From page 30 categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program and the basic topics covered with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Notice of Dementia Training dated December 11, 2021, indicated "assisted living staff will receive required training on dementia care during orientation and annually," and "annually employees will also participate in annual, electronic training or in person related to dementia care." The notice also included the categories of employees trained. The notice lacked a description of the dementia care training program during orientation and lacked a description of the basic topics covered for orientation and annually as required. On February 23, 2022, at 10:51 a.m. licensed	{02260}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{02260}	Continued From page 31 assisted living director (LALD)-A confirmed the licensee's Notice of Dementia Training lacked the above content. The licensee's Assisted Living Dementia Training policy dated August 1, 2021, indicated assisted living staff would receive required training on dementia care during orientation and annually for the required hours and topics. No further information was provided.	{02260}		

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul
651-201-4500

Type: Follow-Up
Date: *02/23/22*
Time: 12:16:59
Report: 7962221030

Food and Beverage Establishment Inspection Report

Location:
River Oaks At Lake Pepin Llc
815 North High Street
Lake City, MN55041
Wabasha County, 79

Establishment Info:
ID #: 0038182
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513452713
ID #:

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

The following orders previously issued on 12/07/21 have NOT been corrected.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

SELF SERVE AREA LEFT DISPLAY COOLER 48 DF FATIMA, 46 DF HARDBOILED EGG, 44DF HANGING THERMOMETER, UNIT TURNED DOWN 40DF HANGING THERMOMETER WORKED WITH FSD(E) & MM(I) TO CORRECT

2-24-22 REISSUED SEE TEMPERATURE LOG

Issued on: 12/07/21 *Comply By: 12/07/21*

5-200B Plumbing: cross connections

5-203.14 ***** Priority 1 *****

MN Rule 4626.1085A Backflow prevention devices must be installed in accordance with chapter 4714.

GARBAGE DISPOSAL DOES NOT HAVE BACKFLOW DISCUSSED WITH FSD(E)

2-23-22 REISSUED WORK WITH A PLUMBER CERTIFIED IN BACKFLOW PREVENTION FOR MOP SINK CHEMICAL CONNECTION AND GARBAGE DISPOSAL

Issued on: 12/07/21 *Comply By: 12/07/21*

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114A ***** Priority 1 *****

MN Rule 4626.0805A Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.

WAREWASHING MACHINE 0PPM, CORRECTED TO 50PPM DURING INSPECTION

Comply By: 02/23/22

4-200 Equipment Design and Construction

4-204.117B ***** Priority 2 *****

MN Rule 4626.0643B Provide a visual or audible signal on the warewashing machine to alert user when detergent and sanitizer are not being delivered during the respective cycles.

NO ALARM ON WAREWASHING MACHINE, CHLORINE SANITIZER 0PPM

Comply By: 02/23/22

8-200 Plan Submission and Approval

8-201.11B ***** Priority 2 *****

MN Rule 4626.1720B Submit complete plans and specifications to the regulatory authority for review and approval at least 30 days prior to beginning any new construction, conversion, change of type of food establishment or food operation, or extensive remodeling of a food establishment.

PLAN REVIEW MAY BE REQUIRED FOR HOOD INSTALLATION

Comply By: 02/23/22

4-200 Equipment Design and Construction

4-201.11BMN

MN Rule 4626.0506B Provide an exhaust ventilation hood that meets the requirements in the Minnesota Mechanical Code, Minnesota Rules, chapter 1346.

NO HOOD OVER OVEN, PLAN REVIEW MAY BE REQUIRED, CONTACT HRD INSPECTOR BEFORE MAKING CHANGES, WORK WITH MECHANICAL ENGINEER FOR ASSISTANCE

Comply By: 02/23/22

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

MISSING CEILING TILES IN DISH MACHINE ROOM AND KITCHEN

Comply By: 02/23/22

Surface and Equipment Sanitizers

Chlorine: = 0ppm at Degrees Fahrenheit
Location: dish machine
Violation Issued: Yes

Chlorine: = 50 ppm at Degrees Fahrenheit
Location: corrected - machine restarted - staff will monitor
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Out of Refrigeration
Temperature: 59 Degrees Fahrenheit - Location: pats of butter
Violation Issued: Yes

Process/Item: Out of Refrigeration
Temperature: 48 Degrees Fahrenheit - Location: cups of milk for lunch service
Violation Issued: Yes

Process/Item: Hot Holding
Temperature: 143 Degrees Fahrenheit - Location: fish
Violation Issued: No

Process/Item: Hot Holding
Temperature: 145 Degrees Fahrenheit - Location: wild rice casserole
Violation Issued: No

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

Process/Item: Hot Holding
Temperature: 173 Degrees Fahrenheit - Location: hamburger
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: sliced tomato
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 33 Degrees Fahrenheit - Location: chicken salad made today
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: cut melon
Violation Issued: No

Process/Item: Out of Refrigeration
Temperature: 47 Degrees Fahrenheit - Location: roast beef salad sandwiches
Violation Issued: Yes

Process/Item: Merchandiser
Temperature: 47 Degrees Fahrenheit - Location: 1/2 gallon milk right self serve cooler
Violation Issued: Yes

Process/Item: Merchandiser
Temperature: 46 Degrees Fahrenheit - Location: sausage patty, egg patty left self serve cooler
Violation Issued: Yes

Process/Item: Thermometer
Temperature: 40 Degrees Fahrenheit - Location: interior thermometer, by cooling plate in back of right self serve glass door cooler, moved to front of cooler
Violation Issued: No

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

Discussed inspection with:
Cori Barker Vice President of Operations
Kai Food Service Director/CFPM
Martin Simons Maintenance Manager

Establishment Info:

12-21-21 report emailed to HRD Nurse Evauluator, Danette Bakken and FPLS Supervisor Matt Finkenbiner

12-7-2021 food service inspection report emailed to HRD Nurse Evauluator, Danette Bakken danette.bakken@state.mn.us

Sent with report:
- Backflow fact sheet for mop sink faucet; faucet does not have backflow protection and is directly connected to a chemical dispenser
- Vomit poster for kitchen; Food Service Director to put near mop sink
- Equipment fact sheet; 2nd page discusses adult care centers
- Temperature Controlled for Safety fact sheet
- Department of Labor and Industry backflow responsibility fact sheet
- Pictures from todays inspection

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7962221030 of 02/23/22.

Certified Food Protection Manager: Kabrie Miller

Certification Number: FM42018 Expires: 11/27/22

Inspection report reviewed with person in charge and emailed.

Signed: _____

Kabrie Miller
Dietary Manager

Signed: Heather Flueger

Heather Flueger
Public Health Sanitarian
Rochester District Office
507-208-3096
heather.flueger@state.mn.us

Report #: 7962221030

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul

No. of RF/PHI Categories Out	2	Date	02/23/22
No. of Repeat RF/PHI Categories Out	1	Time In	12:16:59
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
River Oaks At Lake Pepin Llc	815 North High Street	Lake City, MN	55041	6513452713

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038182		Follow-Up		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 02/24/22

Inspector (Signature) Hunt Flury

Electronically Delivered

January 18, 2022

Administrator
River Oaks At Lake Pepin, LLC
815 North High Street
Lake City, MN 55041

RE: Project Number(s) SL31884015-0

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 9, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for 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 - 1620 - 144g.70 Subd. 2 - Initial Reviews, Assessments, And Monitoring = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the 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:	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

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,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31884	A. BUILDING: _____ B. WING _____	12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT LAKE PEPIN LLC	815 NORTH HIGH STREET LAKE CITY, MN 55041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#31884015 On December 6, 2021, through December 9, 2021, the Minnesota Department of Health visited the above provider and the following correction orders were issued. At the time of the survey, there were 36 residents that were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 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; (12) fails to timely pay any fines assessed by the	0 250		

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0 250	Continued From page 2 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 ensure the management officials who were in charge of the day-to-day operations; and responsible for the assisted living services, understood all of the assisted living provider statues and rules; and the licensee failed to ensure policies and procedures were developed and/or implemented. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 6, 2021, at approximately 10:33 a.m. licensed assisted living director (LALD)-A confirmed she was responsible for and participated in the	0 250		

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0 250	Continued From page 3 facility's day-to-day operations. LALD-A stated she was familiar with the Assisted Living licensing laws and rules. 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 (opens in a new window), 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 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window). - I understand pursuant to Minn. Stat. sect. 13.04	0 250		

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

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0 250	Continued From page 5 the existence of a management agreement or subcontract. - I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable. Page five was electronically signed by the authorized agent on May 8, 2021. The licensee had an Assisted Living license issued on August 1, 2021. The licensee failed to implement the following required policies and procedures: - orientation, training, and competency evaluations of staff - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate - orientation to and implementation of the assisted living bill of rights - infection control practices	0 250		

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0 250	Continued From page 6 - medication and treatment management - delegation of tasks by registered nurses or licensed health professionals. Refer to licensing order at Statute 144G.41, Subd. 3. The licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. Refer to licensing order at Statute 144G.61, Subd. 2. The licensee failed to ensure training and competency evaluations contained all the required training for two of two unlicensed personnel (ULP-F, ULP-G) with records reviewed. Refer to licensing order at Statute 144G.63, Subd. 3. The licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided for two of two unlicensed personnel (ULP-F and ULP-G) with records reviewed. Refer to licensing order at Statute 144G.63, Subd. 4. The licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for one of two employees (ULP-G) with records reviewed. Refer to licensing order at Statute 144G.70, Subd. 2. The licensee failed to ensure reassessment and monitoring for two of two residents (R1 and R2) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 1. The licensee failed to ensure medication errors were investigated and corrective actions were documented for two of	0 250		

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0 250	Continued From page 7 three residents (R6, R9) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 2. The licensee failed to ensure the registered nurse (RN) conducted a medication management assessment for three of three residents (R1, R2, and R3) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 3. The licensee failed to ensure the RN completed reassessment when there was a change in the resident's medications for one of three residents (R2) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 5. The licensee failed to ensure a individualized medication management plan was completed for three of three residents (R1, R2, and R3) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 10. (a)(2). The licensee failed to ensure two of two unlicensed personnel (ULP-F, ULP-G) were trained and had demonstrated competency to prepare and give medications for clients having unplanned time away. Refer to licensing order at Statute 144G.71, Subd. 13. The licensee failed to ensure prescriber's orders for medications were for two of three resident (R1, R3) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 22. The licensee failed to provide a disposition of medications with the required content for one of one discharged resident (R4) with records reviewed.	0 250		

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0 250	Continued From page 8 Refer to licensing order at Statute 144G.72, Subd. 2. The licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 3. The licensee failed to develop a treatment management plan to include all required content and/or was revised as needed for two of two residents (R1, R2) receiving treatments with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 4. The licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records for two of two residents (R1, R2) receiving treatments and had instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures for two of two employees (ULP-F, ULP-G) with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 5. The licensee failed to ensure documentation and administration of treatment as prescribed for one of two residents (R2) receiving treatments with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 6. The licensee failed to ensure prescriber's order for change in treatment for wound care for one of two residents (R2) receiving wound care with records reviewed. Refer to licensing order at Statute 144G.90,	0 250		

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0 250	Continued From page 9 Subd. 1. The licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the residents and a written acknowledgement received for three of three residents (R1, R2, R3) with records reviewed. Refer to licensing order at Statute 144G.91, Subd. 4. The licensed failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) observed with bedrails, with records reviewed. In addition, the licensee failed to document the site of injection for administration of medications for three of four residents (R2, R3, R5) with records reviewed. Thirty-four (34) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes were limited or not evident for compliance with sections 144G.08 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	0 430		

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0 430	Continued From page 10 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 observation, interview, and record review, the licensee failed to provide a copy of the uniform disclosure of assisted living services and amenities (UDALSA) prior to providing assisted living services, for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 and R2 began receiving services under the assisted living licensure on August 1, 2021, and R3 on August 18, 2021. R1 R1's Service Agreement dated October 1, 2021,	0 430		

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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
0 430	Continued From page 11 noted services included, but were not limited to, medication administration, treatment assistance and assistance with activities of daily living. On December 7, 2021, at 11:26 a.m. R1 was observed walking down the hallway with a walker. R2 R2's Service Agreement dated October 1, 2021, noted services included, but were not limited to, medication administration, treatment assistance and assistance with activities of daily living. On December 7, 2021, at 12:55 p.m. R2 was resting in a recliner in his room. R3 R3's Service Agreement dated August 18, 2021, noted services included, but was not limited to, medication administration. R3's Resident Agreement Assisted Living Contract was signed on September 15, 2021, and included the UDALSA being provided at the time the contract was signed, which was after R3 had already began receiving services under the assisted living licensure on August 18, 2021. On December 8, 2021, at 9:05 a.m. licensed assisted living director (LALD)-A stated residents who were residing at the facility prior to August 1, 2021, were not given the UDALSA. LALD-A verified R3 was provided the UDALSA after R3 began receiving services. A policy for the UDALSA was requested, but not provided. No further information was provided.	0 430		

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0 430	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 480		

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0 480	Continued From page 13 a large portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated December 7, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 510		

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0 510	Continued From page 14	0 510		

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:

HANDWASHING
On December 7, 2021, at 7:21 a.m. unlicensed personnel (ULP)-G was observed to administer R5's medications and check a blood sugar. ULP-G washed their hands, applied gloves, gave R5 oral medications with water and handed R5 an inhaler, which R5 self-administered. ULP-G checked R5's blood sugar utilizing a glucometer. With the same gloves, ULP-G administered two insulin shots to R5. ULP-G removed the gloves and handed R5 a nasal spray and an inhaler, which R5 self-administered. ULP-G assisted R5 to put on his shoes, walked out of R5's room and cleansed hands with hand sanitizer, which was located on the medication cart.

On December 9, 2021, at 8:54 a.m. registered nurse (RN)-C stated gloves should be removed and hands washed after checking a blood sugar.

The licensee's policy Blood Glucose Testing dated March 24, 2020, indicated after disposing of test strip (used to place blood on for results of blood sugar level), lancet (a small medical implement used for blood sampling) and gloves hands should be washed.

EMPLOYEE EYE PROTECTION
On December 6, 2021, at 10:28 a.m. food service director (FSD)-E was observed to not be wearing

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0 510	Continued From page 15 eye protection while out in the dining room/hallway area of the lower level. On December 6, 2021, at 11:28 a.m. FSD-E was observed to be bent over talking to a resident seated at a dining room table in the dining room of the lower level. FSD-E was not wearing eye protection. Minnesota Department of Health (MDH) COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated June 30, 2021, indicated health care workers (HCW) with face-to-face contact with residents should wear medical grade well-fitting facemask and eye protection. MDH guidance titled, Responding to and Monitoring COVID-19 Exposures in Health Care Settings, dated December 8, 2021, indicated to institute universal masking of all health care workers for source control. Universal masking is intended to protect both patients and employees from infected health care workers who may shed virus into the environment before onset of symptoms. Institute use of eye protection (e.g., face shield, goggles) as a way to reduce COVID-19 exposure risk. Eye protection is recommended, at a minimum, for all routine outpatient, acute care, and long-term care encounters when PPE supplies allow. Use of all appropriate PPE can reduce the number of exposures for which exclusion from work is recommended. On December 9, 2021, at 8:54 a.m. licensed assisted living director (LALD)-A verified FSD-E should be wearing eye protection.	0 510		

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0 510	Continued From page 16 A policy for COVID-19 was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in quality management activity. This had the potential to affect all 36 residents receiving assisted living 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	0 580		

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0 580	Continued From page 17 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 6, 2021, at 11:15 a.m. licensed assisted living director (LALD)-A stated the licensee had a policy pertaining to quality management activity, but had not engaged in any quality management activities. The licensee's policy Quality Management Plan dated July 20, 2021, indicated "The Assisted Living Director will develop a continuous quality improvement and management program to maintain the agency's continuous performance improvement efforts, consistent with current professional standards and the highest quality services for residents. All staff will be involved in the implementation of performance improvement efforts. The Quality Council meetings will be held at least quarterly to evaluate the quality of care". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number	0 640		

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0 640	Continued From page 18 for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content in common areas to include posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to impact all 36 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living. On December 6, 2021, at 12:30 p.m. observation of the first floor living room revealed a public phone on a table, which licensed assisted living director (LALD)-A stated was where the 911 emergency number was posted. Observation with LALD-A at that time revealed there were no postings of 911 emergency number near the phone. LALD-A stated the posting had been there previously, but was "not here" now.	0 640		

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0 640	Continued From page 19 A policy for posting of emergency number was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines. This had the potential to affect all residents, staff and visitors.	0 660		

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0 660	Continued From page 20 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a written TB infection control plan for the procedures to address early recognition, isolation and referral for handling clients with suspected or confirmed active TB; therefore, none of the licensee's employees had received training on their role in the procedure. The licensee's policy TB Prevention and Control dated July 20, 2021, indicated "If a case of suspected or confirmed TB disease is identified among staff or clients, we assure that appropriate actions will be taken immediately which may include assistance with arrangement for transfer of the client to an inpatient facility while collaborating and cooperating with local public health and MDH [Minnesota Department of Health]". The policy also indicated the licensee would establish and maintain a TB prevention and control program based on the most current guidelines issued by the CDC and the MDH guidelines Regulations for TB control in Minnesota Health Care Settings would be followed. The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a TB infection control	0 660		

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0 660	Continued From page 21 program should include the following: written TB infection control procedures. On December 8, 2021, at 1:54 p.m. registered nurse (RN)-C verified the licensee's policy lacked clear written procedures to address early recognition, isolation and referral for handling clients with suspected or confirmed active TB and therefore, none of the licensee's employees would have received training on their role in the procedure. 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	0 680		

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orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.
(c) The facility must meet any additional requirements adopted in rule.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the licensee failed to post an emergency exit diagram on each floor. In addition, the licensee failed to develop an all-hazards emergency preparedness (EP) program and plan to include Appendix Z required elements. This had the potential to affect all 36 residents in the facility, staff and any visitors.

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

The findings include:

POSTED EMERGENCY EXIT DIAGRAM
The licensee lacked emergency exit diagrams on the first floor of the facility.

On December 6, 2021, at 12:30 p.m. observation of the first floor with licensed assisted living director (LALD)-A revealed there were no posted emergency exit diagrams, which was verified by

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0 680	Continued From page 23 LALD-A. EP PROGRAM AND PLAN On December 8, 2021, at 1:02 p.m. LALD-A, LALD-B and maintenance manager (MM)-I stated the licensee did not have a comprehensive emergency preparedness plan or a policy and procedure for emergency preparedness. LALD-A, LALD-B and MM-I stated they had a meeting with the local fire chief and went through potential hazards. LALD-A stated there was no documentation of the meeting. LALD-A, LALD-B, and MM-I stated the local police would assist with getting generator to the facility and assist to evacuate and transport residents. LALD-A stated the staff received education only through Educare (online training) for emergency preparedness. LALD-A provided an "Incident Pre-Plan" the licensee was in the process of filling out for development of an emergency preparedness plan. MM-I stated the licensee had a risk assessment completed. The licensee Hazard and Vulnerability Assessment Tool Human Related Events dated July 22, 2021, indicated the following hazards: fire, flood, tornado, snow storm, active shooter, power outage, nuclear emergency, gas leak, run away and bomb threat. The licensee provided procedures for "Equipment Emergency" (furnace out, elevator problem, stuck in elevator, fire alarm problem), "Natural Disaster" (tornado, severe thunderstorm, blizzard, fire) and "Evacuation Locations" (back alley, front building); however, the procedures were limited with content, and did not address all identified hazard and vulnerabilities per the assessment dated July 22, 2021.	0 680		

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0 680	Continued From page 24 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 facility failed to provide and maintain the building's physical environment including walls, floors, ceiling, in a continuous state of good repair and operation for health, comfort, and well-being of residents in accordance with a maintenance and repair program. This has the potential to affect all residents of the facility and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 8, 2021, during a facility tour	0 800		

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0 800	Continued From page 25 between 10:30 a.m. and 12:00 p.m. with licensed assisted living director (LALD)-A, LALD-B, and maintenance manager (MM)-I, the following was observed: 1. Resident laundry chute into basement laundry room closet was missing the closer on the door at the top of the chute. The metal chute door had a 90-minute fire rating and is required to have a functioning closer. The open laundry chute connects two floors and is open at the bottom to a hazardous space. The basement laundry room closet does not have a smoke alarm, ventilation, or sprinkler inside it. Surveyor recommended adding a smoke alarm inside the closet and also recommended the licensee contact a local fire code official for additional information. LALD-A stated they would get the chute door fixed and look into adding a smoke alarm at the bottom of it. The licensee lacked documentation for a maintenance plan or schedule for repairs. 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;	0 810		

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	31884	A. BUILDING: _____ B. WING _____	12/09/2021

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0 810	Continued From page 26 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans, failed to provide required training to residents and employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810		

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0 810	Continued From page 27	0 810		

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 December 9, 2021, at approximately 12:00 p.m. the surveyor requested to review the licensee's fire safety and evacuation policy, plans, procedures, schedules, and logs, if available. Upon review the following items were not documented:

1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar, and no written instructions for addressing any unique situation during evacuation especially for residents who are wheelchair-bound and need assistance during an evacuation.

2. No record of required employee evacuation drills. Licensed assisted living director (LALD)-A stated the last fire drill was performed in June of 2020. Maintenance Manager (MM)-I stated that he planned to start fire and evacuation drills once his training was complete. Future drills are scheduled for December 29, 2021, and February 18, 2022.

3. 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.

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0 810	Continued From page 28 4. 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. 5. No fire safety and evacuation plan that showed the location and number of resident rooms. Posted evacuation diagrams include community and service spaces only. LALD-A 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		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and	0 900		

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0 900	Continued From page 29 (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for three of three residents (R1, R2, R3) and failed to offer the resident the opportunity to identify a designated representative for one of three residents (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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 900		

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0 900	Continued From page 30 The findings include: R1 and R2 began receiving services under the assisted living licensure on August 1, 2021, and R3 on August 18, 2021. R1 R1's Service Agreement dated October 1, 2021, noted services included, but were not limited to, medication administration, treatment assistance and assistance with activities of daily living. On December 7, 2021, at 11:26 a.m. R1 was observed walking down the hallway with a walker. R1's record lacked an assisted living contract. R2 R2's Service Agreement dated October 1, 2021, noted services included, but were not limited to, medication administration, treatment assistance and assistance with activities of daily living. On December 7, 2021, at 12:55 p.m. R2 was resting in a recliner in his room. R2's record lacked an assisted living contract. R3 R3's Service Agreement dated August 18, 2021, noted services included, but were not limited to, medication administration. On December 7, 2021, at 11:20 a.m. R3 laid in bed resting. R3's Resident Agreement Assisted Living Contract, was signed on September 15, 2021, which was 28 days after R3 began receiving services under the assisted living licensure.	0 900		

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0 900	Continued From page 31 In addition, the contract failed to address the area of "Designated Representative" or "If Resident declines to name a Designated Representative". On December 7, 2021, at 8:14 a.m. licensed assisted living director (LALD)-A stated residents who were residing at the facility prior to August 1, 2021, were not given a new assisted living contract. LALD-A verified R3's contract was signed after R3 began receiving services under the assisted living licensure. On December 8, 2021, at 10:12 a.m. LALD-A verified R3's contract failed to address the area of "Designated Representative". A policy for assisted living contract was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and	0 910		

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0 910	Continued From page 32 (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of three residents (R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3's Service Agreement dated August 18, 2021, noted services included, but were not limited to, medication administration. On December 7, 2021, at 11:20 a.m. R3 laid in bed resting. R3's Resident Agreement Assisted Living Contract, was signed on September 15, 2021, which was 28 days after R3 began receiving services under the assisted living licensure. R3's contract lacked the following required content: -the contract must include in a conspicuous place and manner on the contract the licensee number of the facility. On December 8, 2021, at 10:12 a.m. licensed assisted living director (LALD)-A verified R3's	0 910		

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0 910	Continued From page 33 contract lacked the above content. LALD-A verified the licensee contract would lack the same for all residents when provided. A policy for assisted living contract was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets.	0 920		

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0 920	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of three residents (R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3's Service Agreement dated August 18, 2021, noted services included, but were not limited to, medication administration. On December 7, 2021, at 11:20 a.m. R3 laid in bed resting. R3's Resident Agreement Assisted Living Contract was signed on September 15, 2021, which was 28 days after R3 began receiving services under the assisted living licensure. R3's contract lacked the following required content: -a delineation of the cost and nature of any other services to be provided for an additional fee On December 8, 2021, at 10:12 a.m. licensed assisted living director (LALD)-A verified R3's contract lacked the above required content. LALD-A verified the licensee contract would lack	0 920		

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0 920	Continued From page 35 the same for all residents when provided. A policy for assisted living contract was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
01370 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all 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	01370		

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01370	Continued From page 36 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: Based on interview and record review, the licensee failed to ensure training and competency evaluations contained all the required training for two of two unlicensed personnel (ULP-F, ULP-G) 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-F had a hire date of November 15, 2021, and ULP-G had a hire date of July 15, 2021. ULP-F and ULP-G's records lacked evidence of training for medication, exercise and treatment reminders.	01370		

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01370	Continued From page 37 On December 7, 2021, at 7:16 a.m. ULP-G verified the staff provided medication administration to R1, R2 and R3 and treatment services to R1 and R2. On December 9, 2021, at 8:54 a.m. licensed assisted living director (LALD)-A and registered nurse (RN)-C verified ULP-F and ULP-G lacked training for medication, exercise and treatment reminders. The licensee policy Administration of Medication, Treatment and Therapy by Unlicensed Personnel dated July 20, 2021, indicated unlicensed personnel that satisfy the training requirements, have been determined competent to follow the procedures and have been delegated the responsibility by the RN, may administer medications. The policy lacked training for medication, exercise and treatment reminders. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01480 SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing assisted	01480		

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living services were oriented specifically to each individual resident and the services to be provided for two of two unlicensed personnel (ULP-F, ULP-G) with records reviewed.

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

The findings include:

ULP-F had a hire date of November 15, 2021, and ULP-G had a hire date of July 15, 2021.

ULP-F and ULP-G's records lacked documentation of orientation to residents receiving care from the licensee.

On December 7, 2021, at 7:16 a.m. ULP-G verified the staff were providing care services to R1, R2 and R3.

On December 8, 2021, at 1:55 p.m. licensed assisted living director (LALD)-A stated the licensee did not document orientation of training to each specific resident. LALD-A further stated the staff received on the floor training for each resident.

The licensee's policy Staff Orientation to Individual Client dated August 1, 2021, indicated staff providing services would be oriented specifically to each individual resident and the services to be provided. The policy did not

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01480	Continued From page 39 address documenting orientation to the resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01480		
01490 SS=D	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training for dementia care was completed as required for one of two unlicensed personnel (ULP-G) 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-G had a hire date of July 15, 2021. On December 7, 2021, at 7:16 a.m. ULP-G stated R1 had left the facility for electroconvulsive	01490		

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therapy (ECT) treatment, and R1 would receive medications upon return to the facility. R1's record included diagnoses of, but not limited to, dementia.

ULP-G's employee record identified the following training for dementia completed on July 19, 2021, which included activities (a balanced approach), communication overview, dementia overview, person centered care, problem solving overview and the face of dementia (the journey) for a total of 5.25 hours.

ULP-G's employee record lacked evidence of receiving at least eight hours total for dementia training within of a total 160 working hours as required.

On December 8, 2021, at 3:15 p.m. licensed assisted living director (LALD)-A verified ULP-G lacked the above training.

The licensee's policy Assisted Living Dementia Training dated August 1, 2021, indicated direct care staff would complete a minimum of eight hours of initial training on dementia care topics within 160 working hours of the employment start date and the training would include the topics of an explanation of Alzheimer's disease and other dementia's, assistance with activities of daily living, problem solving with challenging behaviors, communication skills and person-centered planning and service delivery.

No further information provided.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

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01620 SS=G	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs 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 had completed and/or documented a comprehensive assessment for change in condition for two of three residents (R1, R2) with records reviewed. 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,	01620		

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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:

R1
The licensee lacked a comprehensive nursing assessment by the registered nurse (RN) for a wound (size, appearance, odor, drainage, pain) and for a change in condition related to emergency room visits and hospitalizations.

R1's start of care date was January 28, 2021. R1's diagnoses included, but were not limited to, schizophrenia, dementia, anxiety and severe protein calorie malnutrition.

A provider note dated February 1, 2021, indicated wound foot open right great toe. Use of boot or shoe not required. Evaluation of the wound must be documented on a regular basis, usually at least once monthly. Evaluation must be documented by a health care professional and charted.

R1's Service Agreement was dated October 1, 2021, indicated R1 received the treatment services of, but not limited to, wound care to right greater toe (per provider's orders/nurse to observe and document on right greater toe area weekly).

On December 7, 2021, at 7:16 a.m. unlicensed personnel (ULP)-G stated R1 had left the facility for electroconvulsive therapy (ECT) treatment, and she had provided wound care. ULP-G stated

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R1's wound was located on right foot great toe. R1's right great toe had been amputated due to cellulitis, and stitches had recently been removed. ULP-G stated the wound care included removing the old dressing, cleanse with wound cleanser, apply adaptive dressing, gauze, abdominal pad (ABD), wrap with roll gauze and wrap with ace wrap (compression wrap) every day.

On December 7, 2021, at 11:26 a.m. R1 was observed walking down the hallway with a walker. R1 had a surgical boot and ace wrap in place on the right foot.

R1's Physician Order Sheet dated November 2, 2021, indicated start date October 28, 2021, wound care daily right foot - apply adaptec, apply 4x4 gauze to cover the open area, apply ABD, apply Kerlix (gauze bandage), apply Ace wrap, encourage boot/shoe, encourage minimal walking. Dressing to be changed daily during the a.m. shift.

R1's medication administration record (MAR) dated December 2021, included, but was not limited to, wound care daily on the right foot (apply adaptec, apply 4x4 gauze to cover the open area, apply ABD, apply Kerlix, apply Ace wrap, encourage boot/shoe, encourage minimized walking). Dressing to be changed daily.

R1's record included the following:
-September 10, 2021, "Progress Note" documented by licensed practical nurse (LPN)-K, writer called Mayo store for wound care supplies.

-October 4, 2021, "Progress Note" documented by LPN-J, "RA" (resident assistant) thought the resident's wound on the bottom of the right foot

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was tunneling more. Writer and other nurse manager did dressing change today and other nurse manager thought the area was actually improving. There are no signs or symptoms of infection to the wound, will continue with prescribed dressing change.

-October 6, 2021, "Progress Note" documented by LPN-K, writer performed wound care today and did not observe any redness or warmth to the surround area. Writer noted callus skin around the wound.

-October 7, 2021, "Progress Note" documented by licensed assisted living director (LALD)-A, seen by podiatry, ulcer debrided right foot, continue daily dressing changes.

-October 10, 2021, at 11:01 a.m. "Progress Note" documented by LPN-K, writer observed right amputated toe. Resident has a bruise at point of toe, swelling and warmth to area. Nursing instructed to apply ice pack and elevate the foot. Resident instructed to wear shoes when walking around the facility and outside. At 7:05 p.m., staff informed on call nurse that resident's foot had become more swollen, warm and red. Staff instructed to send to ED (emergency department).

-October 13, 2021, "Progress Note" documented by RN-L, resident returned to facility from hospital. Resident had been admitted with a diagnosis of cellulitis of right foot and received intravenous (IV) antibiotics. Resident will be starting oral antibiotics tomorrow. Dressing changes continue for right foot.

R1's record lacked a reassessment for the change in condition by an RN following

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01620	Continued From page 45 hospitalization. -October 13, 2021, a hospital "After Visit Summary" indicated admitting diagnosis cellulitis foot right, present with right foot swelling and redness and some streaking up his right leg. Admitted, received IV antibiotics. Wound cultures showed Staphylococcus (bacteria). -October 20, 2021, "Progress Note" documented by LALD-A read, Seen at clinic. No new orders. Writer requested a boot to assist with keeping dressing on, clean and off the ground. Results from clinic, finish antibiotic course, continue daily dressing changes, right foot boot provided today. -October 21, 2021, "Progress Note" indicated dietician started high protein supplement. -October 25, 2021, "Progress Note" documented by LPN-J, RA alerted about wound on right foot. Writer observed wound and wound draining moderate amount of brownish drainage. The area is swollen, warm to touch, and does have warm red area going up leg. The wound also has foul odor. Resident seen at clinic this afternoon. -October 25, 2021, "Assisted Living RN Baseline Assessment" documented by RN-D, hospitalized once this quarter for infection of toe. Skin integrity "wound". There was no other information documented regarding the wound. -October 26, 2021, "Progress Note" documented by LPN-J, received call from social worker at hospital. At this time resident will either have cleaning out of wound or more amputation. Resident will not be discharged today. -October 27, 2021, "Progress Note" documented	01620		

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by LALD-A, returned from hospital with diagnosis of osteomyelitis foot acute. New wound care orders.

A "Provider Note" dated October 27, 2021, indicated osteomyelitis wound right first toe. Type of wound: "Surgical." The wound has been debrided. Infection is present. Dressing change daily of adaptec, 4x4 gauze, ABD pad, Kerlix, Ace wrap and use of boot or shoe right side of body.

R1's record lacked a reassessment for the change in condition by an RN following hospitalization.

-October 30, 2021, "Progress Note" documented by LPN-K, observed right foot wound area. The top looks to be bruised, slightly warm to touch, no redness observed. Old dressing removed, area cleansed, dried, new adaptec applied, covered with gauze, ABD pad, Kerlix and Ace wrap.

-November 4, 2021, "Progress Note" documented by LPN-K, appointment at clinic post hospital stay, wound check. Wound is clean and no evidence of infection. Continue present management.

-November 7, 2021, "Progress Note" documented as late entry by LPN-J on November 6, 2021, resident requested to be sent to ER due to swelling, redness, and pain in right foot. Resident returned to facility around 7:00 p.m. No new orders.

R1's record lacked reassessment for the change in condition by a RN following hospitalization.

-November 17, 2021 "Physician Order Sheet", in post-op shoe, no drainage. Continue dressing

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changes daily, return one week to get post-op sutures out. Monitor wound, any changes contact clinic. A "Progress Note" dated November 18, 2021, documented by LPN-J indicated the same.

-November 29, 2021, "Progress Note" documented by LPN-J, had appointment today for follow up with ortho. Orders to continue post-op shoe and dressing for protection until scabs fall off and healed. No drainage, no pain, no tunnel. Healing well. Return two weeks likely discontinue post-op shoe if healed by then, daily dressing changes. Return sooner for concerns/changes.

-December 1, 2021, "Progress Note" documented by LPN-J, had appointment, sutures removed, no new orders.

-December 5, 2021, "Progress Note" documented by LPN-K, resident was sent into ED due to consistent pain and observation of possible infection. Resident returned to the facility an hour later. Resident received pain medication. During wound care this morning there was no observation of redness, warmth or swelling.

R1's record lacked consistent weekly nursing assessments for wounds (size, appearance, odor, drainage, pain), including review of interventions to determine if new interventions were needed to reduce and/or prevent new or worsening of the wound. In addition, the RN failed to complete an assessment following hospitalizations for a change in condition following hospitalization.

R2
The licensee lacked comprehensive nursing assessments by the RN for wounds (size, appearance, odor, drainage, pain) and for a

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change in condition related to emergency room visits and hospitalizations.

R2's start of care date was January 4, 2017. R2's diagnoses included, but were not limited to, diabetes, depression, anxiety, chronic pain and chronic obstructive pulmonary disease (COPD).

R2's Service Agreement dated October 1, 2021. R2's Service agreement included the following treatment services: edema checks (wrap legs in ACE wraps every morning and remove every evening), oxygen assistance (ensure oxygen tubing hooked up to the bilevel positive airway (BIPAP) (a device that helps with breathing) tubing when using BIPAP, oxygen should be at two liters and blood glucose checks three times a day (update nurse if refuses). The service agreement lacked the provision of treatment services of Tubi-grips (tubular elastic bandage used to provide compression) to both lower extremities, BIPAP care and cleaning, wound care for both lower legs and foot wound care.

On December 7, 2021, at 11:20 a.m. ULP-G stated R2 refused ace wraps this a.m.

On December 7, 2021, at 12:55 p.m. R2 was resting in a recliner in his room, and refused to be interviewed by the surveyor.

On December 9, 2021, at 8:08 a.m. ULP-G stated R2 had a small oval shaped open area on the right lower leg below the shin. ULP-G stated R2 refused treatment for wounds most of the time. ULP-G stated she placed gauze soaked in acetic acid solution all around both legs for 10 to 15 minutes, then removed the gauze and placed a non stick gauze pad on the open area. ULP-G stated R2 was to have ace wraps and Tubi-grips

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01620	Continued From page 49 on both legs. ULP-G stated bacitracin (antibiotic) was used on a scabbed crusted area on R2's foot, but there were no open areas and R2 had athlete's foot between the toes. Resident's Individual Abuse Prevention Plan dated September 10, 2021, documented by RN-L, indicated R2 did not consistently follow doctor orders with medications, treatments and wound care. Resident was not easily redirected to follow plan of care and lacked insight into potential risks. Continue to encourage compliance, validate his frustrations. Continue to provide care as ordered. R2's MAR and Service Checkoff List dated December 2021, included but was not limited to, the following tasks: apply ACE wraps (compression wraps) to both lower legs (apply knee high cotton sock, start compression application at the base of your toes, apply two low stretch wraps in figure eight fashion, stop compression right below the knee, wear wraps at all times) and "BLE" (bilateral lower extremity) wound care twice daily (moisten rough gauze with acetic acid solution, apply gauze directly to wound base, allow gauze to sit 10 to 15 minutes, remove gauze dressing and pat dry), Curad elastic sleeve net (tubular stretch bandage) use as directed twice daily for wound care and foot wound care all open wounds (bottom of right foot, cracks of pinky toes) remove old dressing, gently cleanse ulcer base with normal saline and rough gauze in a circular motion. Apply Iodosorb (sterile antimicrobial dressing)/hydrogel (used to promote healing and provide moisture) (50/50) mixture to ulcer base, cover with dry gauze, secure with toe sock and cover roll stretch tape twice daily. R2's record included the following:	01620		

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01620	Continued From page 50 -September 1, 2021, "Progress Notes" documented by RN-L, R2 was seen by a physician assistant certified for wounds on right foot toes. Started Augmentin (antibiotic) twice daily for five days, started Doxycycline (antibiotic) twice daily for five days, daily right foot dressing change: use Vaseline and gauze, right foot cushion boot: wear for five days at least and non-weight bearing, schedule vascular wound care referral, schedule for follow up Friday. -September 7, 2021, "Progress Notes" documented by LPN-K, R2 was seen for a follow up at the clinic. Finish antibiotic course, continue with dressing changes twice daily, set up appointment with the wound clinic, follow up appointment on September 8, 2021. -September 8, 2021, "Progress Notes" documented by LPN-J, R2 was seen at the clinic. Continue with daily dressing changes, return if symptoms worsen or fail to improve. -September 10, 2021, "Assisted Living RN Baseline Assessment" documented by RN-L, R2 has chronic leg wounds, needs encouragement to bathe regularly and allow wound care to be completed. He needs to be reminded of importance of keeping the wounds covered and wearing socks/shoes. Resident has chronic pain and becomes frustrated that he is not able to have narcotics. He has a history of past abuse and providers will no longer prescribe long-term. Resident uses alcohol and marijuana regularly. Resident states it helps his pain. Resident is resistive to utilizing non-pharmacological interventions for pain and becomes upset with staff when he is encouraged to do so. Past medical history indicated R2 was hospitalized in November 2020, and May 2021, and diagnoses	01620		

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was sepsis/cellulitis; in April 2021, with a diagnosis of COPD exacerbation; and in June 2021, with a diagnosis of low oxygen. Skin Integrity indicated "open sores, itching, cellulitis, wound", location of bilateral lower extremities and regularly refuses to wear ACE wraps (compression wraps).

-September 14, 2021, "Progress Notes" documented by LPN-J, follow up from RA regarding resident change "LLE" (left lower extremity), now has strong odor. Writer looked at LLE and the area is damp looking, weepy, and has an odor. Writer requested office manager to schedule a follow up appointment as soon as possible.

R2's record lacked an assessment for the change in skin condition by a RN.

-September 15, 2021, "Progress Notes" documented by LPN-J, R2 refused to go to the appointment he wanted set up for his worsening legs. Both clinical managers were in his room and explained the risks of not going.

-September 16, 2021, "Progress Notes" documented by LPN-J, writer was called by RA to look at resident's "BLE" (bilateral lower extremities). Left lower extremity had a large moist area and there were maggots crawling around the area. Writer also observed a fly on the resident's foot. R2 had refused his dressing change the day before and BLE were left open to the air. Writer reeducated resident on the importance of his follow up appointment the day before. R2 told writer he did not need their "bullshit." RA was instructed to get R2 into the shower and to scrub the BLE well. Writer notified supervisor of the situation. Writer also called

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01620	Continued From page 52 "PCP" (primary care physician) and left a message for her nurse about the situation and requested an order for resident to be seen at the wound clinic. R2's record lacked assessment for the change in skin condition by an RN. -September 17, 2021, "Progress Notes" documented by LPN-K, writer spoke with doctor's nurse on September 16, 2021, at 4:00 p.m. regarding the resident's lower extremities, and asked if the resident should go to the "ED" (emergency department) due to the maggots found on the wound beds; nursing at Mayo stated "no." Writer observed and cleaned resident's lower extremity wounds today. Writer observed and removed one maggot from the resident's left lower extremity. R2 had three weeping areas on the left lower extremity and two weeping areas on the right lower extremity. No redness observed around the moist areas. Warmth was noted to both lower extremities. Writer vigorously cleaned the lower extremities with wound cleaner and gauze to assist with debriding the dead skin off. R2's record lacked an assessment for the change in skin condition by a RN. -September 20, 2021, "Progress Notes" documented by LPN-K, late entry for September 19, 2021, at 7:00 p.m. R2 was sent to ED for "SOB" (shortness of breath), lethargic and weakness. R2 was admitted to the hospital on September 19, 2021. Writer spoke with nursing staff at the hospital. R2 was currently utilizing 2-3 liters of oxygen, having continuous SOB and utilizing abdominal muscles to breathe. Nursing staff stated resident continues to be lethargic and did not want to eat anything. They currently have	01620		

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01620	Continued From page 53 R2 on an oral antibiotic. -September 27, 2021, "Progress Notes" documented by LPN-K, R2 returned to the facility. R2's principal diagnosis upon discharge was acute respiratory failure with hypercapnia (build up of carbon dioxide in bloodstream). R2 has updated wound care orders. Resident will be seeing vascular for wound care needs. R2's record lacked an assessment for the change in condition following a hospitalization by a RN. -October 1, 2021, "Progress Notes" documented by LALD-B, resident was educated on the importance of taking care of wounds and keeping up with self care. Resident has been good at letting the staff clean his legs and perform wound care on his legs. -October 5, 2021, "Progress Notes" documented by LALD-A, resident had a PCP appointment today to follow up from the last hospital stay. At the appointment, his "02" (oxygen) was in the high 80's (percentage of how much oxygen is in the blood). At the appointment, he refused to go to the ER. Upon returning to facility, his PCP followed up and recommended a direct admission to the hospital. R2 was transported and admitted to the hospital. -October 6, 2021, "Progress Notes" documented by LPN-J, late entry for October 5, 2021, at 2:00 p.m. writer was heading to report and was stopped by R2 to talk to the nurse on the phone. Writer spoke with doctor, who asked the writer to take R2's oxygen level. Writer checked level and it was 85-87 percent on room air. Doctor told writer she wanted R2 sent to the ER and she already had a room reserved. R2 was not happy	01620		

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01620	Continued From page 54 about going to hospital, but after writer talked with R2, he agreed to go. -October 7, 2021, "Progress Notes" documented by LALD-A, R2 returned on this date form hospital. Diagnosis of acute and chronic respiratory failure with hypercapnia. R2 returned with his "BIPAP" (bilevel positive airway pressure) to use at night with 2 liters of oxygen. The note further mentioned medication changes. R2's record lacked reassessment for the change in condition following hospitalization by a RN. -October 10, 2021, "Progress Notes" documented by LPN-K, writer observed R2's lower extremities today while assisting staff with wound care. R2's lower extremities did not show signs of infection, no warmth, redness, or drainage observed. -October 12, 2021, "Progress Notes" documented by LPN-J, R2 had an appointment for vascular wound care. The note listed details of wound care for vinegar wound treatment for both legs, skin care (foot cream), wound location/all open wounds (bottom of right foot, cracks of pinky toes), compression both legs (knee high cotton sock/two low stretch wraps). -October 12, 2021 "Wound Clinic Provider Note" indicated wounds on left 5th toe fissure 0.2 centimeters (cm) x 0.7 cm and depth 0.4 cm/full thickness loss involving damage or necrosis of subcutaneous tissue-may extend down to, but not through, underlying fascia and/or missed partial and full thickness and/or tissue layers obscured by granulation, primary dressing wound gel Iodosorb/Hydrogel and cover gauze dressing, change twice daily. Wound right 5th toe fissure 1.3 cm x 1 cm and depth 0.1 cm, partial thickness	01620		

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01620	Continued From page 55	01620		

skin loss involving epidermis and/or dermis, primary dressing wound gel Iodosorb/Hydrogel and cover gauze dressing, change twice daily. Wound right foot plantar 0.7 cm x 0.8 cm and depth 0.1 cm, partial thickness skin loss involving epidermis and/or dermis, primary dressing wound gel Iodosorb/Hydrogel and cover gauze dressing, change twice daily. Evaluation of wound must be documented on a regular basis, usually at least monthly. Evaluation must be documented by health care professional and charted.

-October 20, 2021, "Progress Notes" documented by LALD-A, R2 was seen by PCP on October 19, 2021, and it noted oxygen parameters and medication changes.

-October 23, 2021, "Progress Notes" documented by LPN-K, resident was having low oxygen saturation, nursing assisted R2 with placing the BIPAP on, oxygen increased to 88 percent. R2 was lethargic, hard to arouse, complained of not feeling well and would fall asleep during conversations with staff. R2 was sent to the ED. R2's oxygen saturation with oxygen at three liters was 88 percent. When the ambulance arrived, R2's blood pressure was very low.

-October 24, 2021, "Progress Notes" documented by LPN-K, R2 was admitted to hospital for respiratory failure, metabolic crisis, kidney failure, and dehydration.

-October 28, 2021, "Progress Notes" documented by LALD-A, R2 returned to the facility with a diagnosis of acute respiratory failure. The note indicated the resident had medication changes and received a new BIPAP mask.

R2's record lacked reassessment for the change

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01620	Continued From page 56 in condition following a hospitalization by a RN. -October 31, 2021, 8:33 a.m. "Progress Notes" documented by LPN-K, indicated R2 was sent to ED, would not let staff assist with back pain management and was verbally aggressive towards staff. R2 complained of neck and flank pain. R2 was given a Fentanyl injection at the ED and returned to the facility. At 11:10 a.m., R2 approached staff demanding to be sent into the ED. R2 was observed to have glossy eyes and smelled of alcohol. Writer attempted to assist with treating the back pain, but R2 did not feel good enough and did not want to. R2 was informed they should try to treat in house before going to ED. R2 was also informed if he felt it was severe, he could call for transport and send himself into the ED. R2 was verbally aggressive towards staff, stating "stupid fucking bitch". R2's record lacked a reassessment for the change in condition by a RN. -November 2, 2021, "Progress Notes" documented by LPN-J, R2 was seen by PCP. A new order was received for Tramadol. In addition to the above, documentation revealed on R2's MAR dated November 2021, and December 2021, R2 declined wound care treatment; however, R2's record lacked consistent weekly nursing assessments for wounds (size, appearance, odor, drainage, pain), including review of interventions to determine if new interventions were needed to reduce and/or prevent new or worsening of wounds. On December 6, 2021, at 10:33 a.m. during the entrance conference LALD-A stated the licensee's full-time RN left in October 2021, RN-C	01620		

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01620	Continued From page 57	01620		

(corporate) was the primary RN with varied hours, and RN-D (corporate) worked two days a week. LALD-A stated LPN-J and LPN-K were covering the licensee's building right now. LALD-A stated LPN-J worked full-time, and LPN-K worked three to four days a week. LALD-A stated for ER visits or readmissions after hospitalization, a nurse would see the resident the next day; however, the licensee does not do a full assessment after ER visits or hospitalizations.

On December 9, 2021, at 8:54 a.m. LALD-A and RN-C verified the above. LALD-A stated RN-L's last day to work for the licensee was October 15, 2021. When inquired regarding when wounds started, RN-C stated "a long time ago, [RN-L] was still here and she was concerned about wounds two years ago." RN-C stated the process for assessments of wounds would be when found, to notify the nurse; the nurse would assess; RN would train for specific treatment; and look at wound weekly for progress (worse/better/drainage/infected/odor/increase in size). RN-C stated the licensee "actually have not been measuring wounds unless really bad". RN-C stated the assessment of wounds would be documented in the resident progress notes. LPN-K stated R2 had an open area on right shin which was vascular and a scabbed area under right foot on planter area which was brown and dry. LPN-K stated bactroban (used for skin infection) was being applied to the scabbed area on R2's right foot.

The licensee's policy Initial and On-Going Nursing Assessment or Residents Under the Comprehensive Licensed Agency dated August 1, 2021, indicated the RN would complete a comprehensive nursing assessment of the resident's physical, mental, and cognitive needs

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01620	Continued From page 58 as required for change in resident condition, and RN would complete assessments as indicated by individual resident circumstances. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (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	01650		

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01650	Continued From page 59 chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan contained all required content for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's Service Agreement was dated October 1, 2021. On December 7, 2021, at 11:26 a.m. R1 was observed walking down the hallway with a walker. R2 R2's Service Agreement was dated October 1, 2021. On December 7, 2021, at 12:55 p.m. R2 was resting in a recliner in his room. R3 R3's Service Agreement was dated August 18, 2021. On December 7, 2021, at 11:20 a.m. R3 was	01650		

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01650	Continued From page 60 observed resting in bed. R1, R2 and R3's Service Agreements indicated "Monitoring of Health Related Services: A registered nurse or a licensed practical nurse under the direction of a registered nurse, will review and monitor all health related services provided to the client within 14 days of admission and at least every 62 days thereafter, or more frequently if indicated by a nursing assistant"; and Tier Based Fee Schedule for Private Pay Services" with Tier levels "1" through "6", dollar amounts ranging from $2,500.00 up to $10,000.00 and hours ranging from "2" up to "7" hours of daily services. R1, R2, and R3's service agreements indicated Care Level: "AL" (assisted living) and "Package" listed under each service description had no documented information. There were no specific documented fees for services indicated on R1, R2 and R3's service agreement. R1, R2 and R3's service agreements lacked the following: -the fees for services; -the schedule and methods of monitoring assessments of the resident (lacked initial prior to date on which prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier, 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); -the schedule and methods of monitoring staff providing services; and	01650		

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01650	Continued From page 61 -a contingency plan that included identification of and information as to who had authority to sign for the resident in an emergency On December 9, 2021, at 8:54 a.m. licensed assisted living director (LALD)-A verified R1, R2 and R3's service agreements lacked the schedule and methods of monitoring assessments of the resident, the schedule and methods of monitoring staff providing services, and a contingency plan that included identification of and information as to who had authority to sign for the resident in an emergency, as listed above, and all service plans would lack the same information. In addition, LALD-A verified R3's service agreement lacked the fees for services. The licensee's policy Contents of Service Plan dated July 26, 2021, indicated the service plan content would include fees for services, schedule and methods of monitoring assessments, schedule and methods of monitoring staff providing services and a contingency plan to include identification of and information on who had authority to sign for the resident in an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01690 SS=D	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides	01690		

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01690	Continued From page 62 medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure medicatinon errors were investigated and corrective actions were documented for two of three residents (R6, 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	01690		

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01690	Continued From page 63	01690		

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's Medication Incident Reports indicated the following:
-October 31, 2021, R6 was not administered oxycodone (for pain) 5 milligrams (mg) as ordered. Order was for twice daily as needed and medication was dispensed three times on October 31, 2021. The report indicated corrective action policy and procedure was reviewed, training held - attach document; however, there was no attached document.
-November 26, 2021, R9 received the wrong dose of medication for clozapine. R9 received 150 mg (scheduled for a.m. dose) and was scheduled to receive a p.m. dose of 200 mg. The report indicated for corrective action policy and procedure reviewed, training held - attach document. Education was given to staff; however, there was no attached document.

On December 6, 2021, licensed assisted living director (LALD)-A stated the licensee had not completed education for the medication errors for R6 and R8.

The licensee policy for Medication Error dated March 24, 2020, indicated the director of nursing would determine whether any corrective action needed to systems, training or other procedures is identified and implemented in order to reduce the risk of further occurrence of this type of error and was responsible for documenting the results of the investigation and the corrective actions

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01690	Continued From page 64 taken. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01700 SS=E	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 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.	01700		

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01700	Continued From page 65	01700		

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 an individualized assessment to determine what medication management services would be provided, and how the services would be provided for three of three residents (R1, R2, R3) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R1
R1's Service Plan Agreement dated October 1, 2021, noted services included, but were not limited to, medication administration.

On December 7, 2021, at 7:16 a.m. unlicensed personnel (ULP)-G stated R1 had left the facility for electroconvulsive therapy (ECT) treatment, and R1 would receive medications upon return to the facility.

On December 7, 2021, at 11:26 a.m. R1 was observed walking down the hallway with a walker.

R1's prescriber orders dated October 13, 2021, included two pain relievers, one used to lower

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RIVER OAKS AT LAKE PEPIN LLC	815 NORTH HIGH STREET LAKE CITY, MN 55041

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cholesterol, three vitamins, one used to treat itching, one used to treat nerve pain, one used to treat agitation, one used to treat wheezing or shortness of breath, one used for sleep, four used to treat constipation, one used to treat rash, one used to treat schizophrenia and one used to treat gas.

R1's Brown Bag Medication Review Form dated October 25, 2021, included a review of one used to treat itching, four used to treat constipation, one used to treat schizophrenia and one used to treat gas; reasons for the medications and reported side effects. The review lacked evidence the assessment was conducted face to face with the resident and failed to include a review of all prescribed medications as listed above, including review and identification of indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues, identification of 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.

On December 9, 2021, at 8:54 a.m. licensed assisted living director (LALD)-A and RN-C verified R1's record lacked the above.

R2
R2's Service Plan Agreement dated October 1, 2021, noted services included, but were not limited to, medication administration.

On December 7, 2021, at 7:16 a.m. ULP-G stated

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01700	Continued From page 67 staff administered medications to R2. On December 7, 2021, at 12:55 p.m. R2 was resting in a recliner in his room. R2's prescriber orders dated November 2, 2021, included one used to reduce fluid retention, four used for pain, two used for wheezing or shortness of breath, one used to treat schizophrenia, one used to lower the risk of heart attack, one used to lower cholesterol, one used to treat anxiety, one used to treat athlete's foot, one used to treat depression/anxiety/pain, one used for dry/itchy skin, two used to decrease stomach acid, one used for iron deficiency, one used to decrease swelling and irritation in the airways, two used for allergies, three used for diabetes, one used for seizures, two used to lower blood pressure, one used for diarrhea, one vitamin, one antifungal, one to treat ski infection, one used to treat angina, one used for nausea and one used to treat depression. R2's Brown Bag Medication Review Form dated September 10, 2021, included a list of medications, reasons for medications and reported side effects. The review was not updated to include changes in medications as per R2 prescriber's orders dated November 2, 2021. In addition, the review lacked lacked evidence the assessment was conducted face to face with the resident, review and identification of side effects, contraindications, and actions to address these issues, identification of 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	01700		

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01700	Continued From page 68 manage the resident's medications and prevent diversion of medications. On December 9, 2021, at 8:54 a.m. LALD-A and RN-C verified R2's record lacked the above. R3 R3's Service Plan Agreement dated August 18, 2021, noted services included, but were not limited to, medication administration. On December 7, 2021, at 7:16 a.m. ULP-G stated staff administered medications to R3 at bedtime. On December 7, 2021, at 11:20 a.m. R3 was observed resting in bed. R3's prescriber orders dated October 25, 2021, included one used for depression, one used to treat Parkinson's disease, one used to treat itching caused by allergies, one used to relieve pain and two used to treat schizophrenia. R3's record lacked evidence a medication assessment was conducted face-to-face with the resident, including identification and review of all medications the resident is known to be taking, review and identification of indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues, identification of 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.	01700		

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01700	Continued From page 69 On December 9, 2021, at 8:54 a.m. LALD-A and RN-C verified R3's record lacked the above. The licensee's Initial and On-going Nursing Assessment of Resident's under the Comprehensive Licensed Agency dated July 26, 2021, indicated the RN would review medications the resident was taking for all required content according to current statutes. The assessment was not updated to indicate the licensee had an assisted living license and assessments would be conducted according to assisted living statutes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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 reassessment when there was a change in the resident's medications for one of three residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01710		

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

The findings include:

R2's record lacked evidence or reassessment for review of medications with changes in medication.

R2's Service Plan Agreement dated October 1, 2021, noted services included, but were not limited to, medication administration.

On December 7, 2021, at 7:16 a.m. unlicensed personnel (ULP)-G stated staff administered medications to R2.

On December 7, 2021, at 12:55 p.m. R2 was resting in a recliner in his room.

R2's prescriber orders dated November 2, 2021, included one used to reduce fluid retention, four used for pain, two used for wheezing or shortness of breath, one used to treat schizophrenia, one used to lower the risk of heart attack, one used to lower cholesterol, one used to treat anxiety, one used to treat athlete's feet, one used to treat depression/anxiety/pain, one used for dry/itchy skin, two used to decrease stomach acid, one used for iron deficiency, one used to decrease swelling and irritation in the airways, two used for allergies, three used for diabetes, one used for seizures, two used to lower blood pressure one used for diarrhea, one vitamin, one antifungal, one to treat ski infection, one used to treat

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01710	Continued From page 71 angina, one used for nausea and one used to treat depression. R2's Brown Bag Medication Review Form dated September 10, 2021, included a list of medications, reasons for medications and reported side effects. The review lacked evidence the assessment was conducted face to face with the resident, review and identification of side effects, contraindications, and actions to address these issues, identification of 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. In addition, the review failed to be updated with changes in medications as per R2 prescriber's orders dated November 2, 2021. On December 9, 2021, at 8:54 a.m. licensed assisted living director (LALD)-A and RN-C verified R2's record lacked the above. The licensee's Initial and On-going Nursing Assessment of Resident's under the Comprehensive Licensed Agency dated July 26, 2021, indicated the RN would review medications the resident was taking for all required content according to current statutes. The assessment was not updated to indicate the licensee had an assisted living license and assessments would be conducted according to assisted living statutes. No further information was provided.	01710		

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01710	Continued From page 72 TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
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	01730		

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reactions.
(b) The medication management record must be current and updated when there are any changes.
(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure an individualized medication management plan to include all required content for three of three residents (R1, R2, R3) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R1
R1's Service Plan Agreement dated October 1, 2021, noted services included, but were not limited to, medication administration.

R1's Client Individual Medication Management Plan dated February 13, 2021, indicated R1's medications were secured outside the resident's private home, medications would be administered by unlicensed staff and additional special

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01730	Continued From page 74 instructions for the administration of medications as "None". On December 7, 2021, at 7:16 a.m. unlicensed personnel (ULP)-G stated R1 had left the facility for electroconvulsive therapy (ECT) treatment, and R1 would receive medications upon return to the facility. On December 7, 2021, at 11:26 a.m. R1 was observed walking down the hallway with a walker. R1's prescriber orders dated October 13, 2021, included two used for pain, one used to lower cholesterol, three vitamins (one given intramuscularly (IM) every month), one used to treat itching, one used to treat nerve pain, one used to treat agitation, one used to treat wheezing or shortness of breath, one used for sleep, four used to treat constipation, one used to treat rash, one used to treat schizophrenia and one used to treat gas. R1's Client Individual Medication Management Plan failed to indicate the licensee was storing R1's medications in a locked medication cart, failed to identify a registered nurse (RN) or licensed practical nurse (LPN) would administer the "IM" injection of vitamin B once monthly, and lacked documentation of specific instructions for parameters for as needed (PRN) medications used for pain and constipation (which to administer first/time from scheduled medications) and non-pharmacological interventions to attempt prior to administration of PRN medication used to treat schizophrenia. On December 9, 2021, at 8:54 a.m. licensed assisted living director (LALD)-A and RN-C verified R1's record lacked the above.	01730		

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R2
R2's Service Plan Agreement dated October 1, 2021, noted services included, but were not limited to, medication administration.

On December 7, 2021, at 7:16 a.m. ULP-G stated staff administered medications to R2.

On December 7, 2021, at 12:55 p.m. R2 was resting in a recliner in his room.

R2's Client Individual Medication Management Plan dated October 21, 2021, indicated for medication storage R2's medications were secured outside the resident's private home (insulins stored in fridge) and additional special instructions for the administration of medications as "None".

R2's prescriber orders dated November 2, 2021, included one used to reduce fluid retention, four used for pain, two used for wheezing or shortness of breath, one used to treat schizophrenia, one used to lower the risk of heart attack, one used to lower cholesterol, one used to treat anxiety, one used to treat athlete's foot, one used to treat depression/anxiety/pain, one used for dry/itchy skin, two used to decrease stomach acid, one used for iron deficiency, one used to decrease swelling and irritation in the airways, two used for allergies, three used for diabetes, one used for seizures, two used to lower blood pressure one used for diarrhea, one vitamin, one antifungal, one to treat skin infection, one used to treat angina, one used for nausea and one used to treat depression.

R2's Client Individual Medication Management Plan failed to indicate the licensee was storing

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R2's medications in a locked medication cart and lacked documentation of specific instructions for parameters for as needed (PRN) medications used for pain (which to administer first) and non-pharmacological interventions to attempt prior to administration of PRN medication used to treat anxiety.

On December 9, 2021, at 8:54 a.m. LALD-A and RN-C verified R2's record lacked the above.

R3
R3's Service Plan Agreement dated August 18, 2021, noted services included, but not limited to medication administration.

On December 7, 2021, at 7:16 a.m. ULP-G stated staff administered medications to R3 at bedtime.

On December 7, 2021, at 11:20 a.m. R3 was resting in bed.

R3's Client Individual Medication Management Plan dated August 18, 2021, indicated for additional special instructions for the administration of medications "Nurse administers Invega Sustenna injection once every three weeks" (used to treat schizophrenia).

R3's prescriber orders dated October 25, 2021, included one used for depression, one used to treat Parkinson's disease, one used to treat itching caused by allergies, one used to relieve pain and two used to treat schizophrenia.

R3's Client Individual Medication Management Plan lacked documentation of specific instructions for parameters for as needed (PRN) medications used for pain (which to administer first) and non-pharmalogical interventions to

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01730	Continued From page 77 attempt prior to administration of PRN medication used to treat anxiety and psychotic symptoms. On December 9, 2021, at 8:54 a.m. LALD-A and RN-C verified R3's record lacked the above. A policy for individualized medication management plan was requested, but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for	01790		

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01790	Continued From page 78 giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01790		

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licensee failed to ensure two of two unlicensed personnel (ULP-F and ULP-G) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away 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:

ULP-F had a hire date of November 15, 2021.

ULP-G had a hire date of July 15, 2021.

ULP-F and ULP-G's records lacked evidence to indicate the registered nurse (RN) provided training and determined competency to prepare and administer medications to residents for unplanned times away.

On December 9, 2021, at 8:54 a.m. licensed assisted living director (LALD)-A and RN-C confirmed the licensee's ULP could prepare and send medications with the resident or the resident's responsible person, according to the licensee's policy and procedure. LALD-A and RN-C verified ULP-F and ULP-G who administer medications, were not trained or had not demonstrated competency to prepare or give medications for any of the licensee's residents for unplanned times away.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT LAKE PEPIN LLC	815 NORTH HIGH STREET LAKE CITY, MN 55041

(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
01790	Continued From page 80 The licensee's policy Delegation of Medications to be Given to Clients by Unlicensed Staff for Clients Time Away from Home dated July 26, 2021, indicated only unlicensed staff that have been trained and have satisfactorily demonstrated competency would be assigned to place medications prepared by a pharmacist or a licensed nurse in the appropriate container for an unplanned leave of absence. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure two of three residents (R1, R3) had signed prescriber's orders for medications 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).	01820		

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01820	Continued From page 81 The findings include: R1 R1's record lacked a prescriber's order for as needed (PRN) polyethylene glycol (used to regulate the bowels). R1's medication administration record (MAR) dated December 2021, indicated polyethylene glycol, dissolve 17 grams in at least eight ounces of liquid and give by mouth three times a day PRN for constipation. R1's prescriber's orders dated October 13, 2021, failed to include an order for the above PRN polyethylene glycol. On December 9, 2021, at 8:54 a.m. licensed assisted living director (LALD)-A and registered nurse (RN)-C verified R1's record lacked a prescriber's order for the PRN polyethylene glycol. R3 R3's record lacked a clear prescriber's order for ibuprofen (used for inflammatory pain). R3's prescriber's orders dated October 25, 2021, included an order for ibuprofen 400 milligrams by mouth. R3's MAR dated December 2021, failed to include ibuprofen. R3's record lacked clear prescriber's orders for the ibuprofen to include the frequency for administration or if the medication had been discontinued.	01820		

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01820	Continued From page 82 On December 9, 2021, at 8:54 a.m. LALD-A and RN-C verified R3's record lacked clear prescriber's orders for the ibuprofen to include the frequency for administration or if the medication had been discontinued. A policy for medication prescriber's orders was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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 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	01910		

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01910	Continued From page 83 by: Based on interview and record review, the licensee failed to 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 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 record lacked documentation of medication disposition upon the resident's discharge from the facility. R4 was discharged on August 26, 2021. R4's diagnoses included, but were not limited to, bipolar disorder. R4's Service Plan was requested, but not provided. R4's Progress Note (discharge summary) dated August 30, 2021, indicated R4 was hospitalized for a fracture sustained from a fall and was transferred from the hospital to a care center for recovery and rehab. R4's care team determined	01910		

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01910	Continued From page 84 R4 would indefinitely remain at the care center. The note further indicated R4 received the services of, but not limited to, medication management and activities of daily living assistance while residing at the licensee's assisted living facility. R4's After Visit Summary dated June 7, 2021, included physician orders for one pain medication, one used to lower cholesterol, one skin barrier ointment, one multivitamin, one antidepressant, one used to treat dementia, one used to prevent blood clots, one used to reduce fluid, one used for wheezing/shortness of breath, one used to treat eye allergies, one used for digestion of lactose, one mood stabilizer used for bipolar disorder, one used for bladder relaxant, one used to treat inflammation of the eyes, one laxative, one used to treat bipolar disorder and one used to treat enlarged prostate. On December 7, 2021, at 9:23 a.m. licensed practical nurse (LPN)-K stated R4's medications were sent back to the pharmacy upon discharge. At 9:48 a.m., registered nurse (RN)-C stated there was no record of medication disposition for R4's medications upon discharge from the facility. The licensee's policy Disposition or Disposal of Medication dated July 20, 2021, indicated the licensee would document the destruction, listing the date, quantity name of drug, prescription number, signature of person destroying the drugs and signature of witness to the destruction must be recorded and maintained in the resident's record for two years. The policy further indicated for documentation of the disposition of medications, staff would document the disposition or disposal of medications in the resident's record.	01910		

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01910	Continued From page 85 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to ensure the policy and procedures for treatments and therapy management services included all the 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	01930		

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01930	Continued From page 86 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 6, 2021, at 10:33 a.m. licensed assisted living director (LALD)-A and LALD-B confirmed the licensee provided treatment and therapy services to residents. Review of the licensee's treatment and therapy policies identified the licensee lacked a policy which addressed communicating with residents about treatments or therapy they are receiving. On December 7, 2021, at 10:55 a.m. registered nurse (RN)-C and RN-D verified the licensee lacked a policy which addressed communicating with residents about treatments or therapy they are receiving. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01930		
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	01940		

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01940	Continued From page 87 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 a treatment management plan to include all required content and/or was revised as needed for two of two residents (R1, R2) receiving treatments 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	01940		

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01940	Continued From page 88 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1's Client Treatment or Therapy Management Plan (attachment to service plan) was dated February 2, 2021. The plan indicated treatment or therapy tasks that will be provided were wound care to right greater toe area daily, colostomy care-change two times weekly (Tuesday/Friday)/burp-empty every three hours unlicensed staff/registered nurse (RN)/licensed practical nurse (LPN) would perform the tasks and the RN or LPN would monitor and supervise the service. The plan failed to address: -documentation of specific resident instructions relating to the treatments or therapy administration; -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 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed On December 7, 2021, at 7:16 a.m. unlicensed personnel (ULP)-G stated R1 had left the facility for electroconvulsive therapy (ECT) treatment, and she had provided wound care. ULP-G stated R1's wound was located on the right foot great toe. R2's right great toe had been amputated due to cellulitis and stitches had recently been removed. ULP-G stated the wound care included	01940		

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01940	Continued From page 89 removing the old dressing, cleanse with wound cleanser, apply adaptive dressing, gauze, abdominal pad (ABD), wrap with roll gauze and wrap with ace wrap every day. On December 7, 2021, at 11:26 a.m. R1 was observed walking down the hallway with a walker. R1 had a surgical boot and ace wrap in place on the right foot. R1's Service Agreement dated October 1, 2021, indicated R1 received the treatment services of monitoring for side effects of ECT, wound care to right greater toe (per provider's orders/nurse to observe and document on right greater toe area weekly) and colostomy care assistance (empty every three hours and as needed/change every Friday and as needed/burp or empty every two hours and as needed/assist to empty three times per shift and as needed). R1's medication administration record (MAR) dated December 2021, indicated colostomy set change every Friday, check colostomy bag and burp or empty 2-3 every three hours and wound care daily right foot (apply adaptic, apply 4x4 gauze to cover open area, apply ABD, apply Kerlix (gauze bandage), apply Ace wrap, encourage boot/shoe, encourage minimized walking) dressing to be changed daily. In addition, the plan was not updated with changes for treatment services and failed to include the treatment service of monitoring ECT. On December 9, 2021, at 8:54 a.m. licensed assisted living director (LALD)-A verified R1's Client Treatment or Therapy Management Plan lacked the content listed above and was not updated with changes.	01940		

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01940	Continued From page 90 R2 R2's Client Treatment or Therapy Management Plan (attachment to service plan) was dated September 15, 2020, and indicated no changes. The plan indicated treatment or therapy tasks that will be provided were blood sugar checks three times a day and leg wound care one time a day, unlicensed staff would perform the tasks and the registered nurse (RN) or licensed practical nurse (LPN) would monitor and supervise the service. The plan failed to address: -documentation of specific resident instructions relating to the treatments or therapy administration; -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 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed On December 7, 2021, at 11:20 a.m. ULP-G stated R2 refused ace wraps this a.m. On December 7, 2021, at 12:55 p.m. R2 was resting in a recliner in his room. On December 9, 2021, at 8:08 a.m. ULP-G stated R2 had a small oval shaped open area on right lower leg below the shin. ULP-G stated R2 refuses treatment for wounds most of the time. LPN-J stated R2 continued with cellulitis. ULP-G stated she placed gauze soaked in acetic acid solution all around both legs for 10 to 15 minutes, then removed the gauze and placed a non stick gauze pad on the open area. ULP-G stated R2	01940		

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01940	Continued From page 91 was to have ace wraps and Tubi-grips on both legs. ULP-G stated bacitracin (antibiotic) was used on a scabbed crusty area on R2's foot, but there were no open areas and R2 had athlete's foot between toes. R2's Service Agreement dated October 1, 2021, indicated R2 received the following treatment services: edema checks (wrap legs in ACE wraps every morning and remove every evening), oxygen assistance (ensure oxygen tubing hooked up to the bilevel positive airway (BIPAP) (a device that helps with breathing) tubing when using BIPAP, oxygen should be at two liters and blood glucose checks three times a day (update nurse if refuses). The service agreement lacked the provision of treatment services of Tubi-grips (tubular elastic bandage used to provide compression) to both lower extremities, BIPAP care and cleaning, wound care for both lower legs and foot wound care. R2's medication administration record (MAR) and Service Checkoff List dated December 2021, indicated treatment services being administered by the licensee's staff included: blood sugar checks three times a day, continuous positive airway pressure (CPAP) care in PM daily, CPAP cleaning daily, oxygen administration daily, replace oxygen tubing every other week, apply ACE wraps (compression wraps) to both lower legs (apply knee high cotton sock, start compression application at the base of your toes, apply two low stretch wraps in figure eight fashion, stop compression right below the knee, wear wraps at all times) and "BLE" (bilateral lower extremity) wound care twice daily (moisten rough gauze with acetic acid solution, apply gauze directly to wound base, allow gauze to sit 10 to 15 minutes, remove gauze dressing and pat dry),	01940		

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01940	Continued From page 92 Curad elastic sleeve net (tubular stretch bandage) use as directed twice daily for wound care and foot wound care all open wounds (bottom of right foot, cracks of pinky toes) remove old dressing, gently cleanse ulcer base with normal saline and rough gauze in a circular motion. Apply Iodosorb (sterile antimicrobial dressing)/hydrogel (used to promote healing and provide moisture) (50/50) mixture to ulcer base, cover with dry gauze, secure with toe sock and cover roll stretch tape twice daily. On December 6, 2021, ULP-G documented 'refused acetic acid and wraps but had Tubi-grips on and foot wound care, no open areas.' In addition, the plan was not updated with changes for treatment services and lacked to include the treatment service of BIPAP, wound care to both lower legs, Tubi-grip to both lower extremities and foot wound care On December 9, 2021, at 8:54 a.m. LALD-A verified R2's Client Treatment or Therapy Management Plan lacked the above and was not updated. LPN-K stated R2 had an open area on the right shin which was vascular, and a scabbed area under the right foot on planter area which was brown and dry. LPN-K stated bactroban (used for skin infection) was being applied to the scabbed area on R2's right foot. RN-C informed R2 used a BIPAP. RN-C verified there were parameters for blood sugar checks for when to notify the nurse. The licensee's policy Delegation of Nursing Tasks dated July 26, 2021, indicated the licensee would develop and maintain a current individualized treatment or therapy management record for each resident that addresses the requirements of MN Statutes 144.4793, subd. 3. The policy was	01940		

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01940	Continued From page 93 not updated for reference of MN Statutes 144G.72, subd. 3. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an the registered nurse (RN) specified, in writing, specific instructions for each resident and	01950		

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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
01950	Continued From page 94	01950		

documented those instructions in the resident's records for two of two residents (R1, R2) receiving treatments and had instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures for two of two employees (ULP-F, ULP-G) 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:

R1
R1's Service Agreement dated October 1, 2021, indicated R1 received the treatment services of monitoring for side effects of ECT, wound care to right greater toe (per provider's orders/nurse to observe and document on right greater toe area weekly) and colostomy care assistance (empty every three hours and as needed/change every Friday and as needed/burp or empty every two hours and as needed/assist to empty three times per shift and as needed).

On December 6, 2021, at 12:08 p.m. ULP-F was observed to be working on the floor to providing cares and services to the residents, which included providing treatment services.

On December 7, 2021, at 7:16 a.m. ULP-G stated

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01950	Continued From page 95 R1 had left the facility for electroconvulsive therapy (ECT) treatment, had nothing by mouth (NPO) and would receive medications at 11:00 a.m. upon returning from ECT. ULP-G stated she had provided wound care to R1. ULP-G stated R1's wound was located on right foot great toe. R1's right great toe had been amputated due to cellulitis and stitches had recently been removed. ULP-G stated the wound care included removing the old dressing, cleanse with wound cleanser, apply adaptive dressing, gauze, abdominal pad (ABD), wrap with roll gauze and wrap with ace wrap every day. R1's record lacked specific instructions regarding being NPO prior to ECT treatment. On December 7, 2021, at 11:26 a.m. R1 was observed walking down the hallway with a walker. R1 had a surgical boot and ace wrap in place on the right foot. R1's medication administration record (MAR) dated December 2021, indicated colostomy set change every Friday, check colostomy bag and burp or empty every two to three hours and wound care daily right foot (apply adaptic, apply 4x4 gauze to cover open area, apply ABD, apply Kerlix (gauze bandage), apply Ace wrap, encourage boot/shoe, encourage minimized walking) dressing to be changed daily. R1's MAR dated November 2021, and December 2021, identified ULP-F and ULP-G completed R1's treatments. R1's record lacked specific instructions regarding being NPO prior to ECT treatment. ULP-F had a hire date of November 15, 2021. ULP-F employee record lacked evidence of	01950		

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01950	Continued From page 96 training and competency for the treatment of wound care to R1's right foot and training for ECT. ULP-G had a hire date of July 15, 2021. ULP-G's employee record lacked evidence of training for ECT. On December 9, 2021, at 8:54 a.m. RN-C verified the above treatment services were being provided to R1. RN-C verified ULP-F and ULP-G's employee record lacked evidence of documented training and competency as above. R2 R2's Service Agreement dated October 1, 2021, indicated R2 received the following treatment services: edema checks (wrap legs in ACE wraps every morning and remove every evening), oxygen assistance (ensure oxygen tubing hooked up to the bilevel positive airway (BIPAP) (a device that helps with breathing) tubing when using BIPAP, oxygen should be at two liters and blood glucose checks three times a day (update nurse if refuses). The service agreement lacked the provision of treatment services of Tubi-grips (tubular elastic bandage used to provide compression) to both lower extremities, BIPAP care and cleaning, wound care for both lower legs and foot wound care. On December 7, 2021, at 11:20 a.m. ULP-G stated R2 refused ace wraps this a.m. On December 7, 2021, at 12:55 p.m. R2 was resting in a recliner in his room. On December 9, 2021, at 8:08 a.m. ULP-G stated R2 had a small oval shaped open area on the right lower leg below the shin. ULP-G stated R2	01950		

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01950	Continued From page 97	01950		

refused treatment for wounds most of the time. ULP-G stated she placed gauze soaked in acetic acid solution all around both legs for 10 to 15 minutes, then removed the gauze and placed a non stick gauze pad on the open area. ULP-G stated R2 was to have ace wraps and Tubi-grips on both legs. ULP-G stated bacitracin (antibiotic) was used on a scabbed crusty area on R2's foot, but there were no open areas and R2 had athlete's foot between toes. ULP-G also verified staff assisted R2 with blood sugar checks.

R2's MAR and Service Checkoff List dated December 2021, indicated treatment services were administered by the licensee's staff included: blood sugar checks three times a day 15 to 20 minutes before eating (blood glucose goal 200 or less, contact primary care provider if consistently out of range), continuous positive airway pressure (CPAP) care in PM daily, CPAP cleaning daily, oxygen administration daily (with parameters), replace oxygen tubing every other week, apply ACE wraps (compression wraps) to both lower legs (apply knee high cotton sock, start compression application at the base of your toes, apply two low stretch wraps in figure eight fashion, stop compression right below the knee, wear wraps at all times) and "BLE" (bilateral lower extremity) wound care twice daily (moisten rough gauze with acetic acid solution, apply gauze directly to wound base, allow gauze to sit 10 to 15 minutes, remove gauze dressing and pat dry), Curad elastic sleeve net (tubular stretch bandage) use as directed twice daily for wound care and foot wound care all open wounds (bottom of right foot, cracks of pinky toes) remove old dressing, gently cleans ulcer base with normal saline and rough gauze in a circular motion. Apply Iodosorb (sterile antimicrobial dressing)/hydrogel (used to promote healing and provide moisture)

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01950	Continued From page 98 (50/50) mixture to ulcer base, cover with dry gauze, secure with toe sock and cover roll stretch tape twice daily. R2's MAR and Service Checkoff List, dated November 2021 and December 2021, identified ULP-F and ULP-G were signing for providing the treatments to R2. In addition, R2's MAR dated November 2021, and December 2021, identified R2's blood sugar readings, greater than 400 occurred 24 times in November and seven times in December. Readings greater than 500 occurred three times in November and six times in December, and one reading of 'high' occurred on December 4, 2021. R2's record lacked documentation the RN had been notified of the out of range blood sugars. R2's record lacked specific instructions regarding parameters for blood sugar checks, BIPAP, Tubi-grips and clear instructions for wound care to R2's lower legs and right foot. ULP-F had a hire date of November 15, 2021. ULP-F employee record lacked evidence of training and competency for BIPAP, Tubi-grips, wound care to R2's lower legs and right foot. ULP-G had a hire date of July 15, 2021. ULP-G's employee record lacked evidence of training and competency for BIPAP, Tubi-grips, wound care to R2's lower legs and right foot. On December 9, 2021, at 8:54 a.m. RN-C verified the above treatment services were being provided to R2. LPN-K stated R2 had an open area on the right shin which was vascular, and a scabbed area under right foot on planter area which was brown and dry. LPN-K stated	01950		

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01950	Continued From page 99 bactroban (used for skin infection) was being applied to the scabbed area on R2's right foot. RN-C verified R2 used a BIPAP. RN-C verified there were no specific instructions for parameters of blood sugar checks and when to notify the nurse. At 12:55 p.m., RN-D verified ULP-F and ULP-G's employee record lacked evidence of documented training and competency as above. The licensee's policy Delegation of Nursing Tasks dated July 26, 2021, indicated when a treatment or therapy is delegated or assigned to unlicensed personnel, the RN or authorized Licensed Health Professional would develop and maintain a current individualized treatment or therapy management record for each client that addresses the requirements of MN Statutes 144.4793, Subd. 3, including developing written specific instructions for each client and documenting those instructions in the client's record and before delegating or assigning a task to unlicensed personnel, the RN or Licensed Health Professional would determine each staff member who would perform the task is trained and competent to perform the task and had been instructed in the proper procedures for performing the procedures with respect to the specific client. The policy was not updated for reference of MN Statutes 144G.72, Subd. 4. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an	01960		

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01960	Continued From page 100	01960		

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 documentation and administration of treatment as prescribed for one of two residents (R2) receiving treatments with records reviewed.

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

The findings include:

R2's record lacked evidence of documentation for the treatment of bilevel positive airway (BIPAP) (a device that helps with breathing) and lacked administration of treatment for wound care to right foot as prescribed.

R2's Service Agreement dated October 1, 2021, indicated R2 received treatment services including, but not limited to, oxygen assistance at

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01960	Continued From page 101	01960		

two liters (ensure oxygen tubing hooked up to the BIPAP tubing when using BIPAP) and and foot wound care.

On December 7, 2021, at 12:55 p.m. R2 was resting in a recliner in his room.

On December 9, 2021, at 8:08 a.m. unlicensed personnel (ULP)-G stated bacitracin (antibiotic) was used on a scabbed crusted area on R2's foot, but there were no open areas, and R2 had athlete's foot between toes.

R2's prescriber's order dated September 27, 2021, indicated a diagnoses of chronic obstructive pulmonary disease exacerbation and acute respiratory failure with hypercapnia, with an order for Bi-level PAP, set heated humidity and hose on high. Show patient how to adjust. Optimize interface comfort and fit with patient.

R2's prescriber's order dated November 2, 2021, included, but was not limited to, foot wound care twice daily all open wounds (bottom of foot, cracks of pinky toes) apply Iodosorb (sterile antimicrobial dressing)/hydrogel (used to promote healing and provide moisture) (50/50) mixture to ulcer base, cover with soft dry gauze, secure with toe sock and cover roll stretch tape twice daily.

R2's MAR and Service Checkoff List dated December 2021, indicated treatment services provided included: continuous positive airway pressure (CPAP) care in PM daily and CPAP cleaning daily; foot wound care all open wounds (bottom of right foot, cracks of pinky toes) remove old dressing, gently cleanse ulcer base with normal saline and rough gauze in a circular motion. Apply Iodosorb (sterile antimicrobial dressing)/hydrogel (used to promote healing and

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01960	Continued From page 102 provide moisture) (50/50) mixture to ulcer base, cover with dry gauze, secure with toe sock and cover roll stretch tape twice daily. On December 9, 2021, at 8:54 a.m. RN-C verified R2 used a BIPAP. RN-C also verified R2's record lacked documentation for the treatment service of BIPAP. Licensed practical nurse (LPN)-K stated bactroban (used for skin infection) was being applied to the scabbed area on R2's right foot. The licensee's policy Administration of Medication, Treatment and Therapy by Unlicensed Personnel dated July 20, 2021, indicated unlicensed personnel that would provide assistance with medication, treatment and therapy administration would be trained and competency tested by the RN on documentation, after assistance with self-administration of medications or medication, treatment and therapy administration, consistent with our agency's procedures for documenting the MAR. The policy did not address administering treatments as prescribed. A policy for documenting treatments and prescriber's orders for treatments was requested, but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The	01970		

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01970	Continued From page 103 order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescriber's order for change in wound care treatment for one of two residents (R2) receiving wound care with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's record lacked evidence of prescriber's orders for change in wound care to R2's right foot. R2's Service Agreement dated October 1, 2021, indicated R2 received foot wound care. On December 7, 2021, at 12:55 p.m. R2 was resting in a recliner in his room. On December 9, 2021, at 8:08 a.m. unlicensed personnel (ULP)-G stated bacitracin (antibiotic) was used on a scabbed crusty area on R2's foot,	01970		

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01970	Continued From page 104 but there were no open areas, and R2 had athlete's foot between the toes. R2's prescriber's order dated November 2, 2021, instructed foot wound care twice daily all open wounds (bottom of foot, cracks of pinky toes) apply Iodosorb (sterile antimicrobial dressing)/hydrogel (used to promote healing and provide moisture) (50/50) mixture to ulcer base, cover with soft dry gauze, secure with toe sock and cover roll stretch tape twice daily. R2's MAR and Service Checkoff List dated December 2021, included the following treatments: foot wound care on all open wounds (bottom of right foot, cracks of pinky toes) remove old dressing, gently cleanse the ulcer base with normal saline and rough gauze in a circular motion. Apply Iodosorb (sterile antimicrobial dressing)/hydrogel (used to promote healing and provide moisture) (50/50) mixture to ulcer base, cover with dry gauze, secure with toe sock and cover roll stretch tape twice daily. R2's record lacked a prescriber's order for bacitracin being applied to R2's right foot. On December 9, 2021, at 8:54 a.m. licensed practical nurse (LPN)-K stated bactroban (used for skin infection) was being applied to the scabbed area on R2's right foot. A policy for prescriber's orders for treatments was requested, but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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02240	Continued From page 105	02240		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate	02240		

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because of a complaint.
(d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure a written acknowledgment of receipt of the current home care bill of rights was obtained prior to initiating services for three of three residents (R1, R2, R3) with records reviewed.

This practice resulted in a level one violation (a violation that has not 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:

R1 and R2 began receiving services under the assisted living licensure on August 1, 2021, and R3 on August 18, 2021.

R1
R1's Service Agreement dated October 1, 2021, noted services included, but were not limited to, medication administration, treatment assistance and assistance with activities of daily living.

On December 7, 2021, at 11:26 a.m. R1 was observed walking down the hallway with a walker.

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02240	Continued From page 107 R1's record lacked evidence of written acknowledgment for receiving the assisted living bill of rights. R2 R2's Service Agreement dated October 1, 2021, noted services included, but were not limited to, medication administration, treatment assistance and assistance with activities of daily living. On December 7, 2021, at 12:55 p.m. R2 was resting in a recliner in his room. R2's record lacked evidence of written acknowledgment for receiving the assisted living bill of rights. R3 R3's Service Agreement dated August 18, 2021, noted services included, but were not limited to, medication administration. On December 7, 2021, at 11:20 a.m. R3 was resting in bed. R3's Minnesota Bill of Rights for Assisted Living Clients, written acknowledgement was signed by R3 on September 15, 2021, 28 days after R3 began receiving services under the assisted living licensure. On December 8, 2021, at 9:05 a.m. licensed assisted living director (LALD)-A stated residents who were residing at the facility prior to August 1, 2021, were not provided the assisted living bill of rights. LALD-A verified R3 was provided the assisted living bill of rights after R3 began receiving services on August 18, 2021.	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31884	A. BUILDING: _____ B. WING _____	12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS AT LAKE PEPIN LLC	815 NORTH HIGH STREET LAKE CITY, MN 55041

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02240	Continued From page 108 The licensee's policy Notice of Resident Rights dated August 1, 2021, indicated the licensee would notify residents of their rights before the initiation of services and written acknowledgement of the resident's receipt of the assisted living bill or rights would be obtained or why an acknowledgement could not be obtained would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered 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	02260		

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02260	Continued From page 109 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: R1's Face Sheet dated December 6, 2021, indicated diagnoses included, but were not limited to, dementia in other diseases classified elsewhere with behavioral disturbance. On December 9, 2021, at 12:34 p.m. licensed assisted living director (LALD)-A stated the licensee did not have the written disclosure to provide to residents, families or other persons who requested it. LALD-A stated she did not think the licensee needed to have the information. LALD-A verified the licensee would provide services to persons with dementia. A policy for dementia notice was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02260		
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	02310		

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02310	Continued From page 110 by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) observed with bedrails, with records reviewed. In addition, the licensee failed to document the site of injection for administration of medications for three of four residents (R2, R3, R5) 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: SIDE RAILS On December 7, 2021, at 11:26 a.m. R1 was observed in his room. R1's bed had a bedrail on the left side of the upper half of the bed in the up position. R1's Side Rail Use Assessment Form dated December December 3, 2021, indicated the resident utilized the side rail to help reposition in bed and sit up/lie down in bed. The assessment further indicated the registered nurse (RN) had discussed side rail options with R1 and reviewed the risks and benefits with R1, and side rail use would be assessed quarterly and as needed; however, the assessment lacked documentation of measurements.	02310		

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	31884	A. BUILDING: _____ B. WING _____	12/09/2021

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02310	Continued From page 111 On December 9, 2021, at 8:20 a.m. licensed practical nurse (LPN)-K was observed to measure R1's bedrail in the up position on the left upper half of R1's bed. The bedrail measurements were found to be within the FDA recommended dimensional measurements. Between the rails measured between 2 to 3.5 inches and from the rail to the mattress measured 2 inches. LPN-K stated side rail assessments for residents were completed on admission and quarterly, which included explaining the risk and benefits, but measurements were not obtained. LPN-K stated R1 utilized the side rail for positioning. The licensee's policy Assessing the Safety of Side Rails dated March 24, 2020, indicated when notified the resident had a side rail, the RN would assess and determine whether the side rail/equipment meets the FDA standards for side rails. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails) and zone 3 (space between the rail and mattress), should be less than 4 and 3/4 inches. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by	02310		

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02310	Continued From page 112 the patient's health care team will help to determine how best to keep the patient safe". INJECTION SITE DOCUMENTATION R2 R2's medication administration record (MAR) dated for December 2021, included Basaglar (insulin) Kwikpen inject 80 units subcutaneously (SQ) twice daily and Novolog (insulin) Flexpen inject 20 units SQ with breakfast and lunch and 26 units with dinner and per sliding scale. The MAR indicted the medications were being administered, but lacked documentation of the site in which the medication had been injected. R3 R3's MAR dated for November 2021, included paliperidone palmitate (used to treat schizophrenia) 234 milligrams (mg) per 1.5 milliliters (ml) inject 1.5 ml intramuscularly into the shoulder, thigh or buttocks once every 21 days. The MAR indicted the medication had been administered on November 18, 2021, but lacked documentation of site (shoulder, thigh or buttocks) of where the medication had been injected. R5 On December 7, 2021, at 7:21 a.m. unlicensed personnel (ULP)-G was observed to administer medications to R5, including two insulin injections. At 11:20 a.m., ULP-G verified site of injection for insulin administration was not documented. R5's MAR dated for December 2021, included	02310		

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02310	Continued From page 113 Basaglar Kwikpen inject 35 SQ twice daily and Novolog Flexpen inject 20 units SQ three times a day. The MAR indicted the medications were administered, but lacked documentation of the site in which the medication had been injected. The website Insulin Routines - American Diabetes Association, indicated Insulin Routines; insulin should be injected into the same general area of the body for consistency, but not the exact same place. Insulin delivery should be timed with meals to effectively process the glucose entering your system. Site Rotation; the place on your body where you inject insulin affects your blood sugar level. Insulin enters the blood at different speeds when injected at different sites. Insulin shots work fastest when given in the abdomen. Insulin arrives in the blood a little more slowly from the upper arms and even more slowly form the thighs and buttocks. Injecting insulin in the same general area (for example your abdomen) will give you the best results from your insulin. Don't inject the insulin in exactly the same place each time, but move around the same area. Each mealtime injection of insulin should be given in the same general area for best results. For example, giving your before breakfast injection in the abdomen each day and your before supper insulin injection in the leg each day give more similar blood sugar results. If you inject near the same place each time, hard lumps or extra fatty deposits may develop. Both of these problems make the insulin reaction less reliable. Timing; insulin shots are most effective when you take them so that insulin goes to work when glucose from your food starts to enter your blood. For example, regular insulin works best if you take it 30 minutes before you eat.	02310		

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02310	Continued From page 114 On December 9, 2021, at 8:54 a.m. licensed assisted living director (LALD)-A and registered nurse (RN)-C verified the injection sites for R2, R3 and R5's medications were not documented. The licensee's policy Delegation of Nursing Tasks dated July 26, 2021, indicated prior to delegating medication administration the RN would develop specific written instructions for each resident and document those instructions in the resident's medication record/MAR. No further information 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: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff and	03090		

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03090	Continued From page 115 any visitors of the licensee. This practice resulted in a level one violation (a violation that has not 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 finding include: On December 6, 2021, at approximately 10:10 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices. On December 6, 2021, at 12:08 p.m. cameras were observed to be located in the hallways on the first floor. Unlicensed personnel (ULP)-F stated, "Yes" there were cameras on every floor of the facility. On December 6, 2021, at 12:40 p.m. licensed assisted living director (LALD)-A verified the licensee had no posting at the facility entrance for electronic monitoring as required. A policy for electronic monitoring was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul
651-201-4500

Type: Full
Date: *12/07/21*
Time: 13:00:00
Report: 7962211116

Food and Beverage Establishment Inspection Report

Location:
River Oaks At Lake Pepin Llc
815 North High Street
Lake City, MN55041
Wabasha County, 79

Establishment Info:
ID #: 0038182
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513452713
ID #:

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

The following orders previously issued on 12/07/21 have NOT been corrected.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

SELF SERVE AREA LEFT DISPLAY COOLER 48 DF FATIMA, 46 DF HARDBOILED EGG, 44DF HANGING THERMOMETER, UNIT TURNED DOWN 40DF HANGING THERMOMETER WORKED WITH FSD(E) & MM(I) TO CORRECT

Issued on: 12/07/21 *Comply By: 12/07/21*

5-200B Plumbing: cross connections

5-203.14 ***** Priority 1 *****

MN Rule 4626.1085A Backflow prevention devices must be installed in accordance with chapter 4714.

GARBAGE DISPOSAL DOES NOT HAVE BACKFLOW DISCUSSED WITH FSD(E)

Issued on: 12/07/21 *Comply By: 12/07/21*

5-200B Plumbing: cross connections

5-203.14A ***** Priority 1 *****

MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.

WATER SOFTENER DOES NOT HAVE AN AIR GAP DISCUSSED WITH FSD(E) & MM(I)

Issued on: 12/07/21 *Comply By: 12/07/21*

5-200B Plumbing: cross connections

5-203.14C ***** Priority 1 *****

MN Rule 4626.1085A Provide a reduced pressure zone (RPZ) backflow preventer to protect water distribution lines subject to back pressure, such as the water supply serving a boiler.

MAIN BOILER AND SMALL ROOM BOILERS DO NOT HAVE RPZ BACKFLOW PREVENTERS, DISCUSSED WITH FSD(E) & MM(I)

Issued on: 12/07/21 *Comply By: 12/07/21*

7-200 Toxic Supplies and Applications

7-201.11A ***** Priority 1 *****

MN Rule 4626.1600A Separate poisonous or toxic materials from food, equipment, utensils, linens, and single-service and single-use articles by spacing or partitioning.

SANITIZER SPRAY BOTTLE ADJACENT TO PAPER CONDIMENT PACKETS IN SELF SERVE AREA AND TABLE TOP MIXER IN KITCHEN, FSD(E) CORRECTED, MOVED BOTH DURING INSPECTION

Issued on: 12/07/21 *Comply By: 12/07/21*

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

PROBE THERMOMETER IS NOT SMALL DIAMETER DISCUSSED WITH FSD(E) AND A(A)

Issued on: 12/07/21 *Comply By: 12/07/21*

5-200C Plumbing: Maintenance, fixture location

5-205.13 ***** Priority 2 *****

MN Rule 4626.1120 Inspect, test and maintain water treatment and backflow prevention devices according to the manufacturer's instructions and as necessary to prevent device failure. The person in charge must maintain records of inspection and service of water treatment and backflow prevention devices.

NO DATE OF INSTALLATION ON WATER TREATMENT UNDER SELF SERVE AREA COUNTER DISCUSSED WITH MM(I)

Issued on: 12/07/21 *Comply By: 12/07/21*

Type: Full
Date: *12/07/21*
Time: 13:00:00
Report: 7962211116
River Oaks At Lake Pepin Llc

Food and Beverage Establishment Inspection Report

No NEW orders were issued during this inspection.

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	5	2	0

Establishment Info:

12-21-21 report emailed to HRD Nurse Evauluator, Danette Bakken and FPLS Supervisor Matt Finkenbiner

12-7-2021 food service inspection report emailed to HRD Nurse Evauluator, Danette Bakken danette.bakken@state.mn.us

Sent with report:

- Backflow fact sheet for mop sink faucet; faucet does not have backflow protection and is directly connected to a chemical dispenser
- Vomit poster for kitchen; Food Service Director to put near mop sink
- Equipment fact sheet; 2nd page discusses adult care centers
- Temperature Controlled for Safety fact sheet
- Department of Labor and Industry backflow responsibility fact sheet
- Pictures from todays inspection

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 7962211116 of 12/07/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: Heather Flueger

Heather Flueger
Public Health Sanitarian
Rochester District Office
507-208-3096
heather.flueger@state.mn.us