DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 3, 2022

Administrator
Potter Ridge
1971 Neal Street
Red Wing, MN 55066

RE: Project Number(s) SL30489015

Dear Administrator:

On April 20, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the October 13, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30489	A. BUILDING: _____ B. WING _____	R 04/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POTTER RIDGE	**1971 NEAL STREET RED WING, MN 55066**

(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: SL30489015-2 On April 20, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a revisit survey completed on January 27, 2022. At the time of the survey there were with 39 residents, 38 residents were receiving services under the Assisted Living license. As a result of the revisit, the licensee is in substantial compliance.	{0 000}		
{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	{0 480}		

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{0 480}	Continued From page 1 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: No further action required.	{0 480}		
{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.	{0 810}		

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{0 810}	Continued From page 2 (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}		

Electronically delivered

February 15, 2022

Administrator
Potter Ridge
1971 Neal Street
Red Wing, MN 55066

RE: Project Number(s) SL30489015

Dear Administrator:

On January 27, 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 October 13, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the October 13, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 13, 2021, found not corrected at the time of the January 27, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 = $500.00
0510-Infection Control Program-144g.41 Subd. 3 = $500.00
0550-Resident Grievances; Reporting Maltreatment-144g.41 Subd. 7 = $500.00
0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on January 27, 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 $2,000**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

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

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

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

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
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{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: SL30489015 On January 26, 2022, through January 27, 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 October 13, 2022. At the time of the survey, there were 39 active residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{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 Home Care Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements	{0 470}		

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{0 470}	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and post the required staffing plan. This had the potential to affect the licensee's 39 current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a licensee's health or safety but had the potential to have harmed a	{0 470}		

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{0 470}	Continued From page 2	{0 470}		

resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

The licensee held an assisted living facility license for a capacity of 50 residents; current census was 39 residents.

STAFF POSTING
On January 26, 2022, at approximately 1:46 p.m., during the facility tour, the surveyor observed the licensee's document, Care Giver Staffing Plan, in a frame and posted outside of the licensed assisted living director (LALD)-C's office. The undated posting included the morning shift from 6:00 a.m. to 2:00 p.m. for Care Provider 1 and Care Provider 2, the afternoon shift from 2:00 p.m. to 10:00 p.m. for Care Provider 1 and Care Provider 2, and the overnight shift from 10:00 p.m. to 6:00 a.m. for Care Provider 1.

The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to:
- include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked;
- identify the direct-care staff member's resident assignments or work location; and
- be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building.

STAFFING PLAN
The licensee failed to develop and implement a

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{0 470}	Continued From page 3 staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured that the facility could respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. On January 26, 2022, at approximately 2:50 p.m., unlicensed personnel/lead care manager (ULP)-A stated the staff posting never changed because the staffing needs remained the same every day; therefore, it was not updated daily. ULP-A stated she had been working on a spreadsheet with each resident's service needs and the amount of time needed to provide those services, to help to determine if the licensee had sufficient staff to meet the residents' needs, but stated she wasn't finished with it. On January 27, 2022, at approximately 9:07 a.m., LALD-C stated the licensee had not developed a staffing plan. The licensee's undated, Staffing, Direct Care Staffing Plan, and Daily Schedule policy, indicated the clinical nurse supervisor, or designee, would develop, write, and implement a staffing plan and would provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven days a week, and would develop a 24-hour daily staffing schedule that would be posted at the beginning of each shift, that would include:	{0 470}		

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{0 470}	Continued From page 4 -the direct-care staff work schedules for each direct-care staff member; -indication of all work shifts, including days and hours worked; and -identify direct-care staff member's resident assignments or work location. No further information was provided.	{0 470}		
{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: No further action required.	{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	{0 510}		

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{0 510}	Continued From page 5	{0 510}		

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 deficient practice had the potential to affect the licensee's 39 current residents, staff, and visitors.

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

The findings include:

PERSONAL PROTECTIVE EQUIPMENT (PPE)
The licensee failed to ensure staff consistently wore eye protection while working in the facility.

On January 27, 2022, at approximately 8:07 a.m., the surveyor observed three residents in the dining room and observed cook (C)-I visiting with

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{0 510}	Continued From page 6	{0 510}		

each resident to determine what they wanted for breakfast. C-I stood directly next to or in front of each resident, within one to two feet, to converse with each resident. C-I was wearing a medical-grade face mask; however, she wore no eye protection.

During an interview on January 27, 2022, at approximately 8:15 a.m., C-I stated she remembered a discussion about needing to wear eye protection but stated she didn't know where to go to get the eye protection.

SCREENING OF RESIDENTS
The facility failed to ensure documentation of resident screening for COVID-19 symptoms, including facility practice of daily oxygen and temperature monitoring, for three of three residents (R3, R7, R8) with record review.

R3
R3's service plan dated January 5, 2022, indicated R3 received assistance with housekeeping, checking pendant, meals, laundry, medication administration, daily temperature assessment, and daily oxygen saturation assessment.

R3's RTasks (electronic medical record software used by the licensee) documentation from January 5, 2022, through January 27, 2022, indicated staff recoreded R3's oxygen saturation and temperature six times, on January 7, 8, 9, 17, 25, and 27, 2022, not daily as specified.

R7
R7's service plan dated December 29, 2021, indicated R7 received assistance with dressing, checking pendant, housekeeping, laundry, showers, toileting, daily temperature assessment,

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{0 510}	Continued From page 7 and daily oxygen saturation assessment. R7's RTasks documentation from December 29, 2021, through January 27, 2022, indicated staff recorded R7's oxygen saturation and temperature 19 times, on January 2, 3, 4, 6, 8, 9, 10, 11, 12, 13, 14, 15, 17, 19, 20, 22 (two times), 24, and 26, 2022, not daily as specified. R8 R8's service plan, dated January 3, 2022, indicated R8 received assistance with housekeeping, laundry, meals, medication administration, compression stockings, daily temperature assessment, and daily oxygen saturation assessment. R8's RTasks documentation from January 3, 2022, through January 27, 2022, indicated staff recorded R8's oxygen saturation and temperature five times, on January 7, 8, 9, 17, and 25, 2022, not daily as specified. On January 27, 2022, at approximately 9:57 a.m., registered nurse (RN)-A stated the staff were "getting way better at it", however, verified daily monitoring and recording of oxygen saturation and temperature was not being completed. The licensee's undated policy, Suspected or Confirmed Coronavirus (COVID-19), included, "All residents will have their temperature and oxygen saturation checked at a minimum of daily." The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated June 30, 2021, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative	{0 510}		

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{0 510}	Continued From page 8 residents to wear a medical grade well-fitting facemask and eye protection. The Minnesota Department of Health COVID-19 Toolkit, Information for Long-Term Care Facilities dated March 8, 2021, indicated to prevent unseen spread of COVID-19 in your facility, staff actions include the "use of eye protection (e.g., face shield, goggles) during all resident care encounters as a way to reduce COVID-19 exposure risk to staff. Eye protection is recommended when staff are in a resident care areas. Use of appropriate PPE can reduce staff exposures that might lead to exclusion from work". No further information was provided.	{0 510}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information about the licensee's grievance procedure with the	{0 550}		

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{0 550}	Continued From page 9	{0 550}		

required content. This had the potential to affect the licensee's 39 current residents, staff, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 grievance procedure that included the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, as required.

On January 26, 2022, at approximately 2:50 p.m., during a tour of the facility, the surveyor observed a framed posting of the grievance procedure including the name, telephone number, and e-mail contact information for the individual who was responsible for handling resident grievances, and information related to reporting suspected maltreatment to MAARC. The grievance procedure lacked the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, as required.

On January 26, 2022, at approximately 3:50 p.m., licensed assisted living director (LALD)-C confirmed the required information was not

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{0 550}	Continued From page 10 posted. The licensee's Required Postings policy, undated, noted the community would post information including, but not limited to, MAARC information and reporting number and the grievance procedure, in a conspicuous location. No further information was provided.	{0 550}		
{0 650} SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed	{0 650}		

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{0 650}	Continued From page 11	{0 650}		

by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the employee records contained the required content for five of five employees (registered nurse (RN)-A, RN-B, corporate director of nursing (CDON)-E, unlicensed personnel (ULP)-K, and maintenance director (DM)-J)) 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:

RN-A
RN-A had a hire date of October 29, 2019, and began providing services under the licensee's Assisted Living license on August 1, 2021.

RN-A's record lacked evidence of a job description, including qualifications, responsibilities, and identification of staff persons providing supervision.

On January 27, 2022, at approximately 10:04 a.m., RN-A confirmed her employee record

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{0 650}	Continued From page 12 lacked a job description as required. RN-B RN-B had a hire date of April 12, 2017, and began providing services under the licensee's Assisted Living license on August 1, 2021. RN-B's record lacked documentation of annual performance reviews that identified areas of improvement needed and training needs. On January 27, 2022, at approximately 9:11 a.m., RN-A confirmed RN-B's record did not contain an annual performance evaluation, and stated she hadn't done one for RN-B. CDON-E CDON-E had a hire date of April 30, 2007, and began providing services and oversight under the licensee's Assisted Living license on August 1, 2021. CDON-E's record lacked evidence of the following: - records of orientation, required annual training and infection control training, and competency evaluations; - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - documentation of annual performance reviews that identify areas of improvement needed and training needs. On January 27, 2022, at approximately 2:20 p.m., via telephone interview, CDON-E verified the above missing documents and stated he would send his personnel record information to the surveyor following the survey; however, the information was never received.	{0 650}		

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{0 650}	Continued From page 13 ULP-K ULP-K had a hire date of November 5, 2021. ULP-K's record lacked evidence of the following: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. DM-J DM-J had a hire date of December 15, 2021. DM-J's record lacked evidence of the following: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - documentation of the background study as required under section 144.057. On January 27, 2022, at approximately 1:12 p.m., administrative assistant (AA)-L verified DM-J's missing documents. AA-L was able to print DM-J's background study clearance, dated December 14, 2021, from the Department of Human Services website at that time. The licensee's Personnel Files policy, undated, noted the personnel file would include a current job description, with qualifications, responsibilities and identification of person providing supervision. In addition, the policy noted the file would include evidence of background clearance and a performance evaluation. No further information was provided.	{0 650}		
{0 660} SS=E	144G.42 Subd. 9 Tuberculosis prevention and control	{0 660}		

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{0 660}	Continued From page 14 (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 tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included documentation of a completed TB history and symptom screening for three of three employees (unlicensed personnel (ULP)-K, maintenance director (DM)-J, licensed assisted living director (LALD)-C 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).	{0 660}		

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{0 660}	Continued From page 15 The findings include: During the initial survey entrance conference on October 11, 2021, at approximately 11:40 a.m., the surveyor requested to review the facility TB risk assessment. The TB risk assessment provided was dated July 20, 2021, and indicated the licensee was a "low risk." ULP-K ULP-K had a start date of November 5, 2021. ULP-K's employee record contained evidence of a Quantiferon (detects latent tuberculosis) blood test dated November 29, 2021; however, the record lacked evidence of a completed TB history and symptom screening as required. DM-J DM-J had a start date of December 15, 2021. DM-J's employee record contained evidence of a Quantiferon blood test dated January 3, 2022; however, the record lacked evidence of a completed TB history and symptom screening as required. LALD-C LALD-C had a start date of November 23, 2021. LALD-C's employee record contained evidence of a Quantiferon blood test dated December 7, 2021; however, the record lacked evidence of a completed TB history and symptom screening as required. On January 27, 2022, at approximately 1:12 p.m., administrative assistant (AA)-L verified the recently hired employees' records lacked the	{0 660}		

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{0 660}	Continued From page 16 required information and stated she provided the form to the employees to give to their provider to help them complete it, but the forms were never returned. The licensee's policy, Tuberculosis Testing, undated, indicated a two-step TB test or blood test and TB Screening Tool was required as part of employment with the licensee and directed the employee to provide copies of the medical reports to be kept in the employee's personnel file. The Minnesota Department of Health (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 an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided.	{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	{0 680}		

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{0 680}	Continued From page 17 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan with all of the required content. This had the potential to affect all 39 current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	{0 680}		

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{0 680}	Continued From page 18 On January 26, 2022, at approximately 10:45 a.m., upon entrance to the facility, the surveyor noted an Emergency Preparedness plan posted on a bulletin board in the entryway common area. Also noted, emergency exit diagrams were posted by the elevator on each of the facility's four levels. The licensee's plan lacked a hazard vulnerability assessment and the following required content: - a comprehensive program to include infectious diseases and pandemics; - development of policies/procedures to address: - emergency staff strategies; and - the facility's role in providing care and treatment at alternative sites. - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On January 27, 2022, at approximately 11:24 a.m., maintenance director (DM)-J stated he was recently hired by the licensee and was familiar with the emergency preparedness requirements. DM-J indicated he would be working on the emergency plan to ensure the safety of the licensee's residents and would ensure the plan contained all of the required content. The licensee's Emergency Preparedness Manual policy, undated, noted the community would have an emergency preparedness manual available to staff at all times, and would contain a plan for evacuation, elements of sheltering in place, temporary relocation sites, and details of staff assignments in the event of a disaster or emergency.	{0 680}		

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{0 680}	Continued From page 19 No further information was provided.	{0 680}		
{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	{0 810}		

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{0 810}	Continued From page 20 by: No further action required.	{0 810}		
{01470} SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.	{01470}		

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{01470}	Continued From page 21 (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include the required content for four of four employees (unlicensed personnel (ULP)-A, registered nurse (RN)-A, RN-B, ULP-K) 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	{01470}		

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{01470}	Continued From page 22 found to be pervasive). The findings include: ULP-A ULP-A had a hire date of January 2, 2020, and began providing services under the licensee's Assisted Living license on August 1, 2021. ULP-A's record lacked evidence of the following: - an overview of the Assisted Living statutes; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and - principles of person-centered planning/service delivery. RN-A RN-A had a start date of August 1, 2021. RN-A's record lacked evidence of the following required orientation: - an overview of the Assisted Living statutes; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling emergencies and using emergency services; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and - a review of the types of assisted living services	{01470}		

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POTTER RIDGE	1971 NEAL STREET RED WING, MN 55066

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{01470}	Continued From page 23 the employee will be providing and the facility's category of licensure. RN-B RN-B had a hire date of April 12, 2017, and began providing services under the licensee's Assisted Living license on August 1, 2021. RN-B's record lacked evidence of the following: - an overview of the Assisted Living statutes; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and - principles of person-centered planning/service delivery. ULP-K ULP-K had a hire date of November 5, 2021. ULP-K's record lacked evidence of the following: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling of emergencies and use of emergency services; - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); - the assisted living bill of rights and staff responsibilities related to ensuring the exercise	{01470}		

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{01470}	Continued From page 24 and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On January 27, 2022, at 1:12 p.m., administrative assistant (AA)-L provided a checklist of the licensee's orientation and stated the checklist was followed during the orientation process; however, verified the records for ULP-A, RN-A, RN-B, and ULP-K lacked evidence that orientation was completed. The licensee's All Staff Orientation policy, undated, noted all employees must complete an orientation to the assisted living facility licensing requirements prior to providing services to residents, to include: - an overview of Minnesota's assisted living law; - an introduction and review of agency policies and procedures related to the provision of services; - emergency and disaster training; - the assisted living bill of rights and staff responsibilities to ensuring the exercise and protection of those rights; and	{01470}		

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{01470}	Continued From page 25 - types of services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and provider's scope of licensure. No further information was provided.	{01470}		
{01620} SS=D	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 interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment	{01620}		

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{01620}	Continued From page 26 using the uniform assessment tool no more than 14 days after the initiation of services, for two of four residents (R7, R8) as required, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R7 R7 was admitted for assisted living services on December 28, 2021. R7's diagnoses included history of falling, Parkinson's Disease, hypertension, anxiety and implantable deep brain stimulation device. R7's service plan dated December 29, 2021, indicated R7 received services including assistance with showering, dressing, laundry, housekeeping and vital signs monitoring. R7's Assisted Living Contract was signed on December 29, 2021. R7's record included an unsigned Assessment dated December 29, 2021. R7's following Assessment (intended as the 14-day re-assessment) was dated January 20, 2022, twenty-two (22) days after the initial assessment. R8	{01620}		

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{01620}	Continued From page 27 R8 was admitted for assisted living services on January 3, 2022. R8's diagnoses included chronic kidney disease, muscle weakness and history of falling. R8's service plan dated January 3, 2022, indicated R8 received services including dressing, meals, housekeeping, laundry, medication administration and assistance with compression stockings. R8's Assisted Living Contract was signed on January 3, 2022. . R8's record included an unsigned Assessment dated January 3, 2022. R8's following Assessment (intended as the 14 day re-assessment) was dated January 20, 2022, seventeen (17) days after the initial assessment. On January 27, 2022, at approximately 10:10 a.m., RN-A confirmed R7 and R8's 14-day assessments were not completed timely. The licensee's Initial, Ongoing and Change in Condition Assessment-Evaluation of Residents-AL-MN policy revised September 27, 2021, indicated a registered nurse would coordinate the comprehensive nursing assessments of the resident's physical, mental, and cognitive needs, as required, to include an admission assessment, 14-day assessment, and ongoing assessment no less than every 90 days, and change in resident assessment. The policy did not specify the required initial assessment time frame. No further information was provided.	{01620}		

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{01700}	Continued From page 28	{01700}		
{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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment to determine what medication management services would be provided and how the services would be	{01700}		

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{01700}	Continued From page 29 provided for three of three residents (R3, R6, R8) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the revisit entrance conference on January 26, 2022, at approximately 10:45 a.m., RN-A stated the licensee provided medication management services to residents. R3, R6, and R8's record lacked evidence the RN conducted a medication assessment to include: - an identification and review of all medications the resident was known to be taking. R3 R3's Service Plan dated January 5, 2022, indicated R3 received services including meals, housekeeping, housekeeping and medication administration. R3's clinical update assessment dated November 30, 2021, noted RN-A reviewed R3's medications, including the indication, side effects, allergies and contraindications; however, the assessment lacked identification of what medications were reviewed. R3's prescriber orders dated October 5, 2021, included a blood thinner, an antihypertensive	{01700}		

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{01700}	Continued From page 30 (treats high blood pressure) and a heart medication to treat irregular heart rhythm. R3's Med (Medication) Admin (Administration) Summary for January 2022 had medications as prescribed with staff initials to indicate staff administered the medications. R6 R6's Service Plan dated October 11, 2021, indicated R6 received services including meals, escort, shower assistance and medication administration. R6's admission assessment dated October 11, 2021, noted RN-A reviewed R6's medications, including the indication, side effects, allergies and contraindications; however, the assessment lacked identification of what medications were reviewed. R6's prescriber orders dated September 14, 2021, included an allergy medication, a medication used to treat confusion and an antidepressant. R6's Med Admin Summary for January 2022 had medications as prescribed with staff initials to indicate staff administered the medications. R8 R8's Service Plan dated January 3, 2022, indicated R8 received services including meals, housekeeping, laundry, compression stockings and medication administration. R8's admission assessment dated January 3, 2022, noted RN-A reviewed R8's medications, including the indication, side effects, allergies and contraindications; however, the assessment	{01700}		

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{01700}	Continued From page 31 lacked identification of what medications were reviewed. R8's prescriber orders dated December 3, 2021, included but were not limited to, a pain reliever, vitamin supplements and an anti-hypertensive. R8's Med Admin Summary for January 2022 had medications as prescribed with staff initials to indicate staff administered the medications. On January 27, 2022, at approximately 10:15 a.m., RN-A verified the medication assessments lacked identification of the medications reviewed. The licensee's Assessment Process policy, undated, noted the nursing assessment would include a review of medications including prescriptions, over-the-counter medications and supplements, and for each include the reason taken, side effects, contraindications, allergic or adverse reactions and actions to address those issues. No further information was provided.	{01700}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	{01890}		

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{01890}	Continued From page 32	{01890}		

review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for one of one resident (R5) 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 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:

During the revisit entrance conference on January 26, 2022, at approximately 10:45 a.m., registered nurse (RN)-A stated the licensee provided medication management services to the licensee's residents.

On January 27, 2022, at approximately 11:12 a.m., the surveyor observed unlicensed personnel (ULP)-M use a glucometer to check R5's blood sugar and then returned to the medication cart to prepare to administer R5's insulin. ULP-M obtained R5's Novolog FlexPen from a plastic box with R5's room number from the top drawer of the medication cart. The Novolog FlexPen had a label that included R5's name, room number, date of birth, name of the insulin, and the expiration date; however, the insulin pen lacked a prescription label with the required content. ULP-M indicated RN-A had made the label for the insulin.

On January 27, 2022, at approximately 1:20 p.m.,

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{01890}	Continued From page 33 RN-A stated R8's insulin came in a box with multiple pens and the box contained the pharmacy label, but the pharmacy did not provide labels for each individual pen. RN-A stated she had called the pharmacy but had no success obtaining labels for each pen, so she made labels to attach to the pens. The licensee's Central Storage of Medications policy, undated, lacked information on prescription labels. No further information was provided.	{01890}		

Electronically Delivered

December 8, 2021

Administrator
Potter Ridge
1971 Neal Street
Red Wing, MN 55066

RE: Project Number(s) SL30489015-0

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 13, 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 Home Care 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 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), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00

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
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. 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 client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general Free from Maltreatment reconsideration

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

requests should addressed to:
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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, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. 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

PMB

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0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey investigation. 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#30489015 On October 11, 2021, through October 13, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 35 residents receiving services under the provider's 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 Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 250 SS=F	144G.20 Subdivision 1. Conditions	0 250		

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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
0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04;	0 250		

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0 250	Continued From page 2 (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures as required with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 October 11, 2021, at approximately 11:40 a.m., corporate director of nursing (CDON)-E stated he was familiar with the current assisted living laws and regulations and accessed the regulations online.	0 250		

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0 250	Continued From page 3 CDON-E also indicated he had received training on the new regulations through a provider group. The licensee attested they read and understood the Assisted Living licensing statutes and rules upon application. The licensee was issued an Assisted Living license, effective August 1, 2021. The licensee failed to implement the following required policies and procedures: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Center for Disease Control and Prevention standards; - medication and treatment management. Refer to licensing order at Statute 144G.42, Subd. 6(b). The licensee failed to ensure an individual abuse prevention plan was developed to include the required content for three of three residents (R1, R2, R3) with records reviewed.	0 250		

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0 250	Continued From page 4 Refer to licensing order at Statute 144G.42, Subd. 7. The licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect the licensee's thirty-five (35) current residents. Refer to licensing order at Statute 144G.41, Subd. 7. The licensee failed to post in a conspicuous place, information about the facility's grievance procedure with the required content. This had the potential to affect the licensee's 35 current residents, staff, and visitors. Refer to licensing order at Statute 144G.42, Subd. 8. The licensee failed to ensure the employee record contained the required content for three of four employees (registered nurse (RN)-A, RN-B, and CDON-E) with records reviewed. Refer to licensing order at Statute 144G.63, Subd. 2. The licensee failed to ensure employees received orientation to include the required content for three of three employees (ULP-A, RN-A, and RN-B) with records reviewed. Refer to licensing order at Statute 144G.70, Subd. 2(c). The licensee failed to conduct monitoring and review as needed based on changes in the needs of the resident, for one of one resident (R3) with records reviewed after the resident was hospitalized. Refer to licensing order at Statute 144G.71, Subd. 3. The licensee failed to ensure the RN completed a reassessment for one of one resident (R3) with medication changes, with record reviewed.	0 250		

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0 250	Continued From page 5 Refer to licensing order at Statute 144G.90, Subd. 1. The licensee failed to ensure a written acknowledgement of receipt of the current home care bill of rights was obtained for one of three residents (R3) with records reviewed. 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. This deficient practice had the potential to affect the licensee's 35 current residents, staff, and visitors. Refer to licensing order at Statute 144G.42, Subd. 9. The licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included documentation of a completed TB history and symptom screening for two of four employees (RN-A and RN-B) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 2. The licensee failed to ensure the RN conducted an individualized assessment to determine what medication management services would be provided, and how the services would be provided for one of two residents (R2) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 8. The licensee failed to ensure medications were administered according to manufacturer's instructions for one of one residents (R5) observed for insulin administration. In addition, the licensee failed to ensure	0 250		

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0 250	Continued From page 6 medications were administered as prescribed for one of one resident (R3) with records reviewed, and failed to ensure prescriber orders were transcribed as ordered for one of one resident (R3) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 10 (2). The licensee failed to ensure the registered nurse (RN) developed written procedures for the ULP providing medications for residents having unplanned time away when the licensed nurse was not available. In addition, the licensee failed to ensure one of one (ULP-A) was trained and had demonstrated competency to the RN, to prepare and give medications for residents having unplanned time away. Refer to licensing order at Statute 144G.71, Subd. 20. The licensee failed to ensure medications were maintained bearing the original prescription label with legible information, and failed to date time sensitive medications with a date when opened for two of two residents (R2 and R5) with records reviewed with insulin. Refer to licensing order at Statute 144G.71, Subd. 22. The licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R4) with records reviewed. Refer to licensing order at Statute 144G.72, Subd. 3. The licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R2) with records reviewed.	0 250		

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0 250	Continued From page 7 Twenty-nine (29) correction orders were issued, which indicated the licensee's understanding of the Minnesota Statutes and Rules were limited or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 430 SS=A	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 430		

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0 430	Continued From page 8 licensee failed to provide a copy of the uniform checklist disclosure of services with the required content for one of three residents (R3) 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 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). Findings include: R3's record lacked a uniform checklist disclosure of services to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of all services offered under the contract When interviewed on October 12, 2021, at 8:49 a.m., R3 stated he received services from the facility; however, did not have a current contract and was unaware of the price for the facility room and services. R3 stated, "The bill is different from before. It keeps changing. I have to ask him about that." The licensee lacked a policy regarding the uniform checklist disclosure of services.	0 430		

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0 430	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 470		

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0 470	Continued From page 10 licensee failed to develop and post the required staffing plan potentially affecting the licensee's 35 current residents, staff, and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a licensee'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 holds an assisted living facility license with a bed capacity of 50 residents; current census was 35 residents. STAFF POSTING On October 11, 2021, at approximately 12:10 p.m. during the facility tour, the surveyor observed the licensee's Care Giver Staffing Plan posted outside of the corporate director of nursing (CDON)-E office. The undated posting included the morning shift from 6:00 a.m. to 2:00 p.m. for Care Provider 1 and Care Provider 2, the afternoon shift from 2:00 p.m. to 10:00 p.m. for Care Provider 1 and Care Provider 2, and the overnight shift from 10:00 p.m. to 6:00 a.m. for Care Provider 1. The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident	0 470		

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0 470	Continued From page 11	0 470		

assignments or work location; and
- be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building.

STAFFING PLAN
The licensee failed to develop and implement a staffing plan for determining its staffing level that:
- included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;
- ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and
- ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility.

On October 13, 2021, at approximately 11:51 a.m., the chief financial officer (CFO)-F stated the staff posting never changed because the staffing needs remained the same every day; therefore, it was not updated daily. CFO-F stated the licensee had developed a staffing plan; however, she stated she was unable to provide it at this time.

The licensee's undated, Staffing, Direct Care Staffing Plan, and Daily Schedule policy, indicated the clinical nurse supervisor, or designee, would develop, write, and implement a staffing plan and would provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven days a week, and would develop a 24-hour daily staffing schedule that would be posted at the beginning of each shift, that would include:

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0 470	Continued From page 12 -the direct-care staff work schedules for each direct-care staff member; -indication of all work shifts, including days and hours worked; and -identify direct-care staff member's resident assignments or work location. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
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 and served according to the Minnesota Food Code.	0 480		

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0 480	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 October 11, 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:	0 510		

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0 510	Continued From page 14 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 deficient practice had the potential to affect the licensee's 35 current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: PERSONAL PROTECTIVE EQUIPMENT (PPE) The licensee failed to ensure staff consistently wore face masks and/or eye protection while working in the facility. On October 11, 2021, at approximately 11:40 a.m., the maintenance director (DM)-G greeted surveyors at the door and asked surveyors to screen for COVID-19 symptoms. DM-G was observed wearing a medical-grade mask down below his nose; he wore no eye protection. A resident was observed in the common area at that time. During a facility tour on October 11, 2021, at approximately 12:10 p.m., the community life coordinator (CLC)-H was observed sitting in the dining room at lunchtime with no protection. Several residents were sitting within six feet of CLC-H.	0 510		

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0 510	Continued From page 15 On October 11, 2021, at approximately 2:39 p.m., the cook (C)-I walked into the nurse's office without a mask or eye protection. Registered Nurse (RN)-A asked C-I if she needed a mask. C-I covered her mouth with both of her hands and said, "No." On October 11, 2021, at approximately 2:46 p.m., RN-A stated, "They [all staff] should be wearing masks and goggles." When asked if prescription glasses were sufficient, RN-A stated, "We have the clippies on the side for people with glasses." On October 12, 2021, at approximately 7:30 a.m., C-I was observed in the dining room wearing a medical-grade facemask, but no eye protection while residents where eating breakfast. C-I wore prescription eyeglasses and stated she typically has clips to put on them, but forgot them at home. On October 12, 2021, at approximately 7:55 a.m., unlicensed personnel (ULP)-A was observed to provide medication administration to residents, wearing a medical-grade face mask and prescription eyeglasses, but no other eye protection. At 8:03 a.m., ULP-A stated prescription eyeglasses were okay to wear as eye protection. On October 12, 2021, at approximately 11:00 a.m., DM-G approached ULP-A at the medication cart. DM-G was observed to have a medical-grade mask over his nose and mouth, and to wear eye goggles. DM-G stated to ULP-A, he didn't know how a person could wear the goggles all the time, as they fog up. On October 12, 2021, at approximately 11:30 a.m., corporate director of nursing (CDON)-E	0 510		

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0 510	Continued From page 16	0 510		

stated he had talked to DM-G about wearing his mask incorrectly and stated he would have another conversation with him about wearing the goggles.

On October 12, 2021, at approximately 1:26 p.m., a female with darker colored hair, wearing black scrubs, was observed vacuuming the resident dining area, within six feet of an unidentified staff member, and was not wearing eye protection.

On October 13, 2021, 12:32 p.m., an unidentified female, wearing a floral scrub top and blue scrub pants, was observed in the lobby of the facility, within approximately five feet of a male resident, without a mask. When RN-A was asked to identify the female, RN-A stated, "a physical therapist from an outside agency." When asked if visitors were expected to wear a mask, RN-A stated, "Yes."

SCREENING OF RESIDENTS
The facility failed to ensure documentation of resident screening for COVID-19 symptoms, including facility practice of daily oxygen and temperature monitoring, for one of one resident (R3), with record review.

R3's Service plan, dated August 27, 2021, indicated R3 received assistance with housekeeping, checking pendant, dressing, meals, laundry, temperature assessment, oxygen saturation assessment, toileting, escort services, and medication administration.

R3's Master Care Plan, dated August 27, 2021, indicated oxygen saturation and temperature would be monitored daily.

R3's RTasks documentation from September 1,

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0 510	Continued From page 17 2021 through October 12, 2021, indicated R3 had oxygen saturation and temperature recorded only once, on September 18, 2021, not daily as specified. On October 12, 2021, at approximately 3:12 p.m., RN-A indicated that all residents' oxygen saturation values and temperatures were to be obtained daily, and symptom screen questions were to be asked. RN-A stated, "Doing oxygen and temperatures has gone by the wayside. Once a day is what it's supposed to be." When asked if the COVID-19 screening questions and answers were documented in the resident record, RN-A stated, "It's not on the treatment administration record (TAR)." HEALTH CARE WORKER RETURN TO WORK FOLLOWING POSITIVE COVID-19 Review of ULP-B's employee record, indicated ULP-B had a COVID-19 test performed on September 14, 2021, that resulted in positive results, dated September 15, 2021, at 10:57 a.m. RN-A was asked to provide a schedule of the days that ULP-B worked in September 2021. RN-A provided a list of dates that ULP-B did not work. The list indicated that ULP-B was off from September 13, 2021, through September 21, 2021. On October 13, 2021, at approximately 11:50 a.m., RN-A stated she was uncertain of when ULP-B reported symptoms of illness to the facility before testing positive for COVID-19. When asked if any additional screening measures were implemented, or any protocol initiated after learning of the COVID-19 positive test result, RN-A stated that ULP-B was taken off of the schedule; however, no additional measures were	0 510		

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0 510	Continued From page 18 taken. On October 13, 2021, at approximately 1:21 p.m., the chief financial officer (CFO)-F stated ULP-B worked the night of October 12th, until 6:00 a.m. on October 13th, 2021, therefore, only eight (8) days elapsed between ULP-B testing positive for COVID-19, and ULP-B's return to work at the facility. The licensee's undated policy, Suspected or Confirmed Coronavirus (COVID-19), indicated "Staff Quarantine Guidelines: A. Staff with symptoms are quarantined for 10 days since the onset of symptoms, and no fever for 24 hours without the use of fever reducing medications and symptoms are improved. B. Staff without symptoms and positive COVID-19 test are quarantined for 10 days since they swabbed positive for COVID-19, unless they develop symptoms then use the criteria for staff with symptoms." The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated June 30, 2021, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a medical grade well-fitting facemask and eye protection. The Minnesota Department of Health COVID-19 Toolkit, Information for Long-Term Care Facilities dated March 8, 2021, indicated to prevent unseen spread of COVID-19 in your facility, staff actions include the "use of eye protection (e.g., face shield, goggles) during all resident care encounters as a way to reduce COVID-19 exposure risk to staff. Eye protection is recommended when staff are in a resident care	0 510		

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0 510	Continued From page 19 areas. Use of appropriate PPE can reduce staff exposures that might lead to exclusion from work". The Minnesota Department of Health COVID-19 Recommendations for Health Care Workers(HCW), dated September 29, 2021, indicated a minimum of 10 days off of work after a positive COVID-19 result is the best practice for facilities. "HCWs with mild to moderate illness who are not severely immunocompromised: At least 24 hours have passed since recovery, defined as resolution of fever without the use of fever reducing medications and improvement in symptoms (e.g., cough, shortness of breath); AND, At least 10 days have passed since symptoms first appeared. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by:	0 550		

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0 550	Continued From page 20 Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's 35 current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On October 11, 2021, at approximately 11:00 a.m., upon entering the facility, an observation of the main entry area noted no required posting of the grievance procedure and information related to reporting suspected maltreatment to MAARC. On October 11, 2021, at approximately 12:10 p.m., during the facility tour with corporate	0 550		

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0 550	Continued From page 21 director of nursing (CDON)-E, the above required information was not observed to be posted throughout the facility. At this time, CDON-E confirmed the required information was not posted. The licensee's Required Postings policy, undated, noted the community would post information including, but not limited to, MAARC information and reporting number and the grievance procedure in a conspicuous location. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to display the original current license at the main entrance as required. 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:	0 570		

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0 570	Continued From page 22 On October 11, 2021, at approximately 11:00 a.m., upon entering the facility, the license was not observed to be posted at the facility entrance as required. On October 11, 2021, at approximately 12:10 p.m. during the facility tour with corporate director of nursing (CDON)-E, the license was observed to be posted outside CDON-E's office, inside the facility approximately 25 feet, and around the corner. At this time, CDON-E confirmed the license was not posted at the front entrance as required. The licensee's Required Postings policy, undated, noted items to be posted in the community, including, but not limited to, any licenses to be posted at the main entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes	0 630		

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0 630	Continued From page 23 self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include specific measures to minimize the risk of abuse to the residents for three of three residents (R1, R2, and R3) 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 On October 12, 2021, at approximately 8:03 a.m., R1 was observed in her room, seated in a recliner, reading the newspaper. R1's Assessment dated August 30, 2021, indicated R1's vulnerabilities included she was at risk for falling; however, the assessment did not include specific measures to minimize the risk. R1's Master Care Plan-With Services dated August 30, 2021, indicated R1 needed supervision to ensure safety when transferring due to unsteadiness, used a wheeled walker, and staff were to ensure shoes were on when ambulating. An Incident Report dated August 28, 2021,	0 630		

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0 630	Continued From page 24 indicated R1 was walking in her bathroom using her walker, lost her balance while attempting to move her wheelchair up against the wall, and fell to the floor. R1 sustained a scrape to her arm with no other injury. Interventions included educating R1 to press her pendent to ask for assistance from staff. An Incident Report dated August 30, 2021, indicated R1 was attempting to grab a bandage in the bathroom, lost her balance, fell sideways, and was found on the ground. R1 had no injury. Interventions included registered nurse (RN)-A requested an occupational therapy evaluation. An Incident Report dated September 9, 2021, indicated R1 lost her balance while being assisted off of the toilet, she slowly fell to her bottom, and bumped her head on the wall. There were no injuries. R1 was not wearing anything on her feet at the time of the fall. Interventions included staff to ensure R1 have on grip socks or shoes for all transfers. An Incident Report dated September 13, 2021, indicated R1 was reaching down to grab masks while holding the table and fell backwards landing on her bottom. R1 denied injury. Interventions included education to use grabber when trying to get something off the floor. An Incident Report dated September 20, 2021, indicated R1 had a witnessed fall while walking into the bathroom with her walker. R1 attempted to move her walker to the right, went to take a step forward, and tripped on the wheel of the walker. R1 fell to her knees and caught herself with the toilet. R1 denied injury. Interventions include removal of bathroom rug for safety.	0 630		

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0 630	Continued From page 25 On October 12, 2021, at approximately 3:05 p.m., RN-A confirmed R1's vulnerabilities included she was at risk for falling and verified the Assessment document did not include specific measures to minimize the risk. R2 On October 12, 2021, at approximately 11:15 a.m., unlicensed personnel (ULP)-A was observed performing a blood glucose check on R2 in his apartment. R2's assessment dated September 7, 2021, noted R2's vulnerabilities to include risk for abuse; vulnerable adult reports were filed on the resident's behalf and guardianship/conservatorship had been applied for to help prevent further abuse. It also noted poor hygiene and a high risk for further foot infection; however, the assessment lacked statements of specific measures to be taken to minimize the risk of abuse. R2's Service Plan dated June 14, 2021, indicated R2 received services including, but not limited to, glucometer checks and medication administration. On October 13, 2021, at approximately 10:15 a.m., RN-A verified R2's assessment lacked statements of specific measures to be taken to minimize the risk of abuse. R3 On October 12, 2021, at approximately 8:09 a.m., R3 was interviewed in his apartment while sitting at his desk. R3's assessment dated August 28, 2021, noted vulnerabilities that included:	0 630		

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0 630	Continued From page 26 -Multiple Sclerosis Cachexia -Dry flaky skin intact -Balance problems while standing -Balance problems while walking -Drinks moderately or occasionally a beer -Self isolates-is pleasant but prefers to be in his apartment, does not participate in most activities -Difficulty weighing advice, has impaired judgement-he is very particular about placement of objects in his apartment. He is very organized. He may not keep his walker next to him for safety, instead he will request it to be up against the wall in its place. He may not wear his pendent due to personal preference. -Behavior-other-is very particular about placement of items in apartment, very organized. -Mental illness-other-mild cognitive impairment. Although vulnerabilities were identified, the assessment lacked statements of specific measures to be taken to minimize the risk of abuse. On October 13, 2021, at approximately 10:15 a.m., RN-A verified R3's assessment lacked statements of specific measures to be taken to minimize the risk of abuse. The licensee's policy, Community Abuse Prevention Plan-Minnesota, undated, identified the licensee would develop an individual abuse prevention plan that included statement of the specific measure to be taken to minimize the resident's risk. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 640	Continued From page 27	0 640		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect the licensee's thirty-five (35) current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	0 640		

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0 640	Continued From page 28 The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility; and - post information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. On October 11, 2021, at approximately 12:10 p.m., during the facility tour with corporate director of nursing (CDON)-E, the above required information was not observed to be posted throughout the facility. At this time, CDON-E confirmed the required information was not posted. The licensee's Required Postings policy, undated, noted items to be posted in the community, including, but not limited to, 911 emergency number in common areas and by the facility provided telephones and MAARC information and reporting number. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure,	0 650		

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0 650	Continued From page 29 registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for three of four employees (registered nurse (RN)-A, RN-B, and corporate director of nursing (CDON)-E) 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	0 650		

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0 650	Continued From page 30	0 650		

limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

RN-A
RN-A had a start date of August 1, 2021.

RN-A's record lacked evidence of a job description, including qualifications, responsibilities, and identification of staff persons providing supervision.

On October 13, 2021, at approximately 10:45 a.m., RN-A confirmed her employee record lacked a job description as required.

RN-B
RN-B had a hire date of April 12, 2017, and began providing services under the licensee's Assisted Living license on August 1, 2021.

RN-B's record lacked evidence of the following:
- current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and
- documentation of annual performance reviews that identify areas of improvement needed and training needs.

CDON-E
CDON had a hire date of April 30, 2007, and began providing services and oversight under the licensee's Assisted Living license on August 1, 2021.

CDON-E's record lacked evidence of the following:

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0 650	Continued From page 31 - records of orientation, required annual training and infection control training, and competency evaluations; - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - documentation of annual performance reviews that identify areas of improvement needed and training needs. On October 13, 2021, at approximately 1:27 p.m., chief financial officer (CFO)-F verified the above missing documents and indicated personnel records should be complete with required content and available when requested. The licensee's Personnel Files policy, undated, noted the personnel file would include a current job description, with qualifications, responsibilities and identification of person providing supervision. In addition, the policy noted the file would include record of home care orientation, and a performance evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity	0 660		

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0 660	Continued From page 32 and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included documentation of a completed TB history and symptom screening for two of four employees (registered nurse (RN)-A and RN-B) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During the entrance conference on October 11, 2021, at approximately 11:40 a.m. with corporate director of nurses (CDON)-E and RN-A, a request was made to review the facility TB risk assessment. The TB risk assessment provided was dated July 20, 2021, and indicated the licensee was a "low risk."	0 660		

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0 660	Continued From page 33 RN-A had a start date of October 29, 2019. RN-A's employee record contained evidence of a Quantiferon (detects latent tuberculosis) blood test dated October 24, 2019; however, the record lacked evidence of a completed TB history and symptom screening as required. RN-B had a start date of April 12, 2017. RN-B's employee record contained evidence of a two-step tuberculin skin test dated May 30, 2017, and June 13, 2017; however, the record lacked evidence of a completed TB history and symptom screening as required. On October 13, 2021, at approximately 10:45 a.m., RN-A confirmed her record did not contain a TB history and symptom screening. She stated she assumed that employees completed the TB history and symptom screening at the Clinic when they completed their blood test. She stated she did not have copies of it in employee records. RN-A stated, with new hires, she just looked for "the word negative" on their TB results. The licensee's policy, Tuberculosis Testing, undated, indicated a two-step TB test or blood test and TB Screening Tool was required as part of employment with the licensee and directed the employee to provide copies of the medical reports to be kept in the employee's personnel file. The Minnesota Department of Health (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 an annual facility TB risk assessment. The	0 660		

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0 660	Continued From page 34 guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not	0 680		

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0 680	Continued From page 35 received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all 35 current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 October 11, 2021, at approximately 11:40 a.m., a request was made to view the licensee's emergency preparedness plan, which was provided later and reviewed by the surveyors. On October 11, 2021, at approximately 12:10 p.m., MDH surveyors toured the facility with corporate director of nursing (CDON)-E. The facility's physical layout included one building with resident rooms located on all four levels. Upon entering the facility, an open common area was	0 680		

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0 680	Continued From page 36 noted with a large staircase leading to the second level. Along the left side of the staircase, there was the bulletin board, and behind the staircase, the hall to the resident rooms on that level. Emergency exit diagrams were not noted to be posted in the common areas, but only in each resident room on the back side (inside the apartment) of each door. The licensee's plan provided lacked a hazard vulnerability assessment. The plan provided included: - emergency telephone numbers - the disaster response team - a disaster policy - emergency equipment inventory checklist - fire disaster plan - tornado/severe weather disaster plan - tornado drill plan - bomb threat/explosion plan - blizzard/heavy snow plan - water shortage - water contamination - flooding plan - power loss - missing resident plan - elopement plan - death of a resident plan - natural gas leak plan - workplace violence - active shooter The plan lacked the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations;	0 680		

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0 680	Continued From page 37 - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situations; - development of policies/procedures to address: - evacuation plan - shelter in place - the medical record documentation system to preserve resident information - emergency staff strategies - the facility's role in providing care and treatment at alternative sites - a communication plan that included: - arrangement with other facilities - names and contact information for resident physicians - contact information for federal, state, tribal, local EP staff, or the ombudsman - primary and alternative means for communicating with facility staff, or federal, state, regional and local emergency management agencies - a method of sharing information and medical documentation for residents - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy -a method of sharing information from the emergency plan with residents and their families - EP training and testing program - EP training program for staff (including documentation of training provided) - EP testing/annual testing requirements On October 13, 2021, at approximately 1:25 p.m., chief financial officer (CFO)-F stated the information provided regarding the emergency preparedness plan was everything they had. The licensee's Emergency Preparedness Manual	0 680		

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0 680	Continued From page 38 policy, undated, noted the community would have an emergency preparedness manual available to staff at all times, and would contain a plan for evacuation, elements of sheltering in place, temporary relocation sites, and details of staff assignments in the event of a disaster or emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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	0 810		

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0 810	Continued From page 39 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 provide documentation of policy, schedule, and log of staff training for fire safety and evacuation procedures. It also failed to provide documentation of required staff evacuation drills. 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 October 12, 2021, at approximately 1:45 p.m. while reviewing emergency preparedness procedures, the licensee provided evidence that new employees were trained upon hire. No evidence was provided for required twice per year staff training, once per year resident training, or employee evacuation drills. On October 12, 2021, at approximately 1:50 p.m., corporate director of nursing (CDON)-E	0 810		

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0 810	Continued From page 40 confirmed the facility had not developed a plan or schedule for required training and evacuation drills. A policy related to a plan for required training of employees, training of residents, and evacuation drills was requested, but not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer	0 900		

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0 900	Continued From page 41 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 interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for one of two 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On August 1, 2021, new assisted living law went into effect in the State of Minnesota. R3 was living in the facility prior to August 1, 2021, and continued to reside there as of October 11, 2021. On October 12, 2021, at approximately 8:09 a.m., R3 was interviewed in his apartment. The	0 900		

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0 900	Continued From page 42 surveyor asked R3 if he received services from the facility, had a contract, and was aware of the price for the facility room and services. R3 stated, "No. The bill is different from before. It keeps changing. I have to ask him about that." R3 showed the surveyor a copy of his last bill from the facility. R3 stated, "I was getting medication 4 times a day, but then it changed to two times a day." R3's record included a contract that was uploaded on October 12, 2021, that was signed by corporate director of nursing (CDON)-E on August 1, 2021; however, R3 did not sign the contract until September 1, 2021, or 31 days after starting services with the licensee under the assisted living licensure. The licensee lacked a policy regarding the resident contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
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;	0 920		

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0 920	Continued From page 43 (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1 and 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 R3's records lacked a written contract to include: - 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.	0 920		

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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
0 920	Continued From page 44 R1's Service Plan dated August 30, 2021, indicated R1 received assistance with housekeeping, dressing, meals, showering, transferring, and toileting. R3's Service Plan dated August 27, 2021, indicated R3 received assistance with housekeeping, checking pendant, dressing, meals, laundry, temperature assessment, oxygen saturation assessment, toileting, escort services, and medication administration. On October 13, 2021, at approximately 11:48 a.m., chief financial officer (CFO)-F confirmed the residents' contracts did not include the above required content, and verified each of their residents' contracts were the same and lacked the same content. The licensee's Signing a Resident Agreement policy, undated, lacked the required contents of the written contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 940 SS=C	144G.50 Subd. 2 Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers;	0 940		

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	30489	A. BUILDING: _____ B. WING _____	10/13/2021

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0 940	Continued From page 45 (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R3) with record 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	0 940		

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0 940	Continued From page 46 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 R3's records lacked a written contract to include: - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required. R1's Service Plan dated August 30, 2021, indicated R1 received assistance with housekeeping, dressing, meals, showering, transferring, and toileting. R3's Service Plan dated August 27, 2021, indicated R3 received assistance with housekeeping, checking pendant, dressing, meals, laundry, temperature assessment, oxygen saturation assessment, toileting, escort services, and medication administration. On October 13, 2021, at approximately 11:48 a.m., chief financial officer (CFO)-F confirmed the residents' contracts did not include the above required content, and verified each of their residents' contracts were the same and lacked the same content. The licensee's Signing a Resident Agreement policy, undated, lacked the required contents of the written contract. No further information was provided.	0 940		

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0 940	Continued From page 47 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.	01470		

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01470	Continued From page 48 (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include the required content for three of three employees (unlicensed personnel (ULP)-A, registered nurse (RN)-A, RN-B) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	01470		

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01470	Continued From page 49 found to be pervasive). The findings include: ULP-A ULP-A had a hire date of January 2, 2020, and began providing services under the licensee's Assisted Living license on August 1, 2021. ULP-A's record lacked evidence of the following: - an overview of the Assisted Living statutes; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and - principles of person-centered planning/service delivery. On October 13, 2021, at approximately 1:25 p.m., chief financial officer (CFO)-F stated the licensee completed training for staff on the orientation requirements, but confirmed ULP-A had not received the required training. RN-A RN-A had a start date of August 1, 2021. RN-A's record lacked evidence of the following required orientation: - an overview of the Assisted Living statutes; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling emergencies and using emergency	01470		

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01470	Continued From page 50	01470		

services;
- the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and
- a review of the types of assisted living services the employee will be providing and the facility's category of licensure.

On October 13, 2021, at approximately 10:45 a.m., RN-A confirmed her employee record lacked the required orientation, and stated she did not know if she had received it or not.

On October 13, 2021, at approximately 1:25 p.m., CFO-F stated the licensee completed training for staff on the orientation requirements, but confirmed RN-A was unable to attend and had not received the required training.

RN-B
RN-B had a hire date of April 12, 2017, and began providing services under the licensee's Assisted Living license on August 1, 2021.

RN-B's record lacked evidence of the following:
- an overview of the Assisted Living statutes;
- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;
- the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;
- a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and
- principles of person-centered planning/service delivery.

On October 13, 2021, at approximately 1:25 p.m.,

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01470	Continued From page 51 CFO-F stated the licensee completed training for staff on the orientation requirements, but could not confirm RN-B attended the training because she worked as an "on-call" staff. The licensee's All Staff Orientation policy, undated, noted all employees must complete an orientation to the assisted living facility licensing requirements prior to providing services to residents, to include: - an overview of Minnesota's assisted living law - an introduction and review of agency policies and procedures related to the provision of services - emergency and disaster training - the assisted living bill of rights and staff responsibilities to ensuring the exercise and protection of those rights - types of services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and provider's scope of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors;	01560		

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01560	Continued From page 52 (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. 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. This had the potential to affect all residents. 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: When interviewed on October 13, 2021, at 1:17 p.m., registered nurse (RN)-A indicated the licensee provided services to residents with dementia and other related disorders. On October 13, 2021, at approximately 1:28 p.m., chief financial officer (CFO)-F stated the licensee had a written description of the licensee's dementia care training program, but was unable	01560		

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01560	Continued From page 53 to provide it. The licensee's Dementia Training policy, undated, indicated a description of the training program, categories of employees trained, the frequency of training, and basic topics covered, would be provided to consumers in writing or electronic form to residents and families or other persons who request it, and a hard copy would be made available upon request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01620 SS=D	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	01620		

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01620	Continued From page 54 section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an assessment after a changes in the needs of the resident for one of one resident (R3) with records reviewed after R3 was hospitalized. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was hospitalized from October 1, 2021, through October 5, 2021. R3's hospital discharge summary, dated October 5, 2021, contained medication discontinuation and new medication information and a summary of R3's hospitalization. On October 11, 2021, R3's record lacked a current and up-to-date assessment following R3's hospitalization and change of condition. On October 12, 2021, at approximately 8:09 a.m., R3 was interviewed in his apartment. When asked if he had seen a nurse between the time of his October 5, 2021 hospital discharge until	01620		

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01620	Continued From page 55 today, R3 stated, "No I haven't seen the nurse." On October 12, 2021, at approximately 9:17 a.m., R3's record included an assessment that was not noted in the record the previous day, entitled "Clinical update assessment," dated October 11, 2021, which included the following: "Digoxin [treats irregular heartbeat] taken every other day. Diltiazem [prevents chest pain] cut in half and given every 6 hours as scheduled." Both of those medications were discontinued before R3 was discharged from the hospital, and Amiodarone (treats serious irregular heartbeat) was started. These medication changes were included in R3's discharge summary from the hospital dated October 5, 2021, which indicated, "You were admitted for atrial fibrillation in the setting of missed doses. When you were here, we switched you from digoxin to amiodarone for heart rhythm control. We also performed cardioversion to shock your heart into a regular rhythm." On October 13th, 2021, at 10:43 a.m., registered nurse (RN)-A verified the licensee's most recent assessment of R3 was completed late in the day on October 11, 2021. RN-A stated the information was obtained from R3 when he slipped a note under her door, which included a list of the medication changes that were made while he was hospitalized. RN-A stated the most recent assessment was not completed face-to-face with R3. The licensee's undated policy, Monitoring of Residents and Their Services, read, "The RN will assess the resident any time the resident returns from a hospital or nursing home stay, has a change in condition, experiences an incident such as a fall, or experiences any unusual symptoms or possible side effects from medications."	01620		

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01620	Continued From page 56 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	01620		
01650 SS=C	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 chapters. This MN Requirement is not met as evidenced	01650		

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01650	Continued From page 57 by: Based on interview and record review, the licensee failed to ensure the service plan included the schedule and methods of monitoring assessments for three of three residents (R1, R2, and 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 R1's Service Plan, effective August 30, 2021, indicated R1 received services including, but not limited to, assistance with housekeeping, dressing, meals, showering, transferring, and toileting. The service plan incorrectly indicated the schedule and methods of monitoring assessments of the resident to include the initial assessment would be completed within five days after initiation of home care services. R2 R2's Service Plan dated June 14, 2021, indicated the resident received services including, but not limited to, glucometer checks and medication administration. The service plan incorrectly indicated the schedule and methods of monitoring assessments of the resident to include the initial assessment would be completed within five days after initiation of home care services.	01650		

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01650	Continued From page 58 R3 R3's Service plan, dated August 27, 2021, and signed by R3 on September 27, 2021, indicated R3 received assistance with housekeeping, checking pendant, dressing, meals, laundry, temperature assessment, oxygen saturation assessment, toileting, escort services, and medication administration. The service plan incorrectly indicated the schedule and methods of monitoring assessments of R3 to include the initial assessment would be completed within five days after initiation of home care services. On October 12, 2021, at approximately 3:20 p.m., chief financial officer (CFO)-F confirmed the service plan contained the language from the old regulations regarding the schedule and methods of monitoring assessments of residents. The licensee's Service Plan Agreement policy, undated, noted the service plan would include the schedule and methods of monitoring assessment of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37	01700		

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01700	Continued From page 59 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. 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 one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01700		

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01700	Continued From page 60	01700		

limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

During the entrance conference on October 11, 2021, at approximately 11:40 a.m., RN-A stated the licensee provided medication management services to residents.

R2's record lacked evidence the RN conducted a medication assessment to include:
- an identification and review of all medications the resident was known to be taking.

R2's Service Plan dated June 14, 2021, indicated R2 received services including, but not limited to, glucometer checks and medication administration.

R2's change of condition assessment dated July 22, 2021, noted the nurse reviewed R2's medications, including the indication, side effects, allergies, and contraindications; however, the assessment lacked identification of what medications were reviewed.

On October 12, 2021, at approximately 11:15 a.m., unlicensed personnel (ULP)-A was observed performing a blood glucose check on R2 in his apartment.

R2's prescriber orders dated August 24, 2021, included two insulin medications to control high blood sugars and one statin medication to control high cholesterol.

R2's Med (Medication) Admin (Administration) Summary for October 2021 had medications as

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01700	Continued From page 61 prescribed with staff initials to indicate staff administered the medications. On October 13, 2021, at approximately 10:15 a.m., RN-A verified the medication assessment lacked identification of the medications reviewed. The licensee's Assessment Process policy, undated, noted the nursing assessment would include a review of medications including prescriptions, over-the-counter medications and supplements, and for each include the reason taken, side effects, contraindications, allergic or adverse reactions, and actions to address those issues. 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 interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment of a resident's medication management services after medication changes for one of one resident (R3) with record reviewed.	01710		

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01710	Continued From page 62	01710		

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 included:

R3 was hospitalized from October 1, 2021, through October 5, 2021.

R3's hospital discharge summary dated October 5, 2021, contained medication discontinuation and new medication information and a summary R3's hospitalization.

On October 11, 2021, R3's record lacked a current and up-to-date assessment following R3's hospitalization and change of condition.

On October 12, 2021, at approximately 8:09 a.m., R3 was interviewed in his apartment. When asked if he had seen a nurse between the time of his October 5, 2021, hospital discharge until today, R3 stated, "No I haven't seen the nurse."

On October 12, 2021, at approximately 9:17 a.m., R3's record included an assessment that was not noted in the record the previous day, entitled "Clinical update assessment," dated October 11, 2021, which included under the medication section, the following: "Digoxin [treats irregular heartbeat] taken every other day. Diltiazem [prevents chest pain] cut in half and given every 6 hours as scheduled." Both of those medications

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01710	Continued From page 63 were discontinued before R3 was discharged from the hospital, and Amiodarone (treats serious irregular heartbeat) was started. These medication changes were included in R3's discharge summary from the hospital dated October 5, 2021, from the hospital and read, "You were admitted for atrial fibrillation in the setting of missed doses. When you were here, we switched you from digoxin to amiodarone for heart rhythm control. We also performed cardioversion to shock your heart into a regular rhythm." On October 13th, 2021, at 10:43 a.m., RN-A verified R3's most recent medication assessment was completed late in the day on October 11, 2021. RN-A stated the information was obtained from R3 when he slipped a note under her door, which included a list of the medication changes that were made while he was hospitalized. RN-A stated the most recent assessment was not completed face-to-face with the resident or by telecommunication means. The licensee's undated policy, Nursing Assessment, indicated the RN would reassess the resident any time the resident returned from a hospital or nursing home stay, has a change in condition, experiences any unusual symptoms or possible side effects from medications. Also included, the policy directed the RN would evaluate the resident's medication management services and the resident's medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	01710		

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01760	Continued From page 64	01760		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to manufacturer's instructions for one of one resident (R5) observed for insulin administration. The licensee failed to ensure medications were administered as prescribed for one of one resident (R3) with records reviewed, and failed to ensure prescriber orders were transcribed as ordered for one of one resident (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01760		

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01760	Continued From page 65 The findings include: FOLLOWING MANUFACTURER'S INSTRUCTIONS R5's Novolog FlexPen insulin was not administered per manufacturer recommendations for use. R5's service plan and prescriber orders copies were requested but not provided. R5's September 2021 Med (medication) Admin (administration) Summary noted Novolog FlexPen 20 units subcutaneously 100 unit/milliliter daily at 11:30 a.m. The summary included staff initials to indicate the insulin was administered. On October 12, 2021, at approximately 11:00 a.m., unlicensed personnel (ULP)-A was observed preparing R5's insulin. ULP-A removed the pen, attached a needle, and dialed the insulin pen to 20 units. At this time, ULP-A stated she had asked about priming the insulin pen as she had been instructed at another facility, but was told it was not necessary to waste the 2 units with priming. On October 13, 2021, at approximately 10:35 a.m., registered nurse (RN)-A stated she does not expect insulin pens to be primed by staff prior to drawing up the prescribed dose. RN-A stated they run into problems with the pharmacy saying they should have medication left, if they prime the pen. Novolog Insulin FlexPen manufacturer's guide dated May 2016 directs to prime the pen with 2 units and make sure a drop appears prior to each use before selecting a dose.	01760		

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01760	Continued From page 66 The licensee's Administration of Insulin policy, undated, indicated "If you are using insulin pens, you must dial up 2 units to prime the pen and discard it with each administration of insulin." ADMINISTERED AS PRESCRIBED/ORDER NOT TRANSCRIBED On October 12, 2021, at approximately 8:09 a.m., R3 was interviewed while sitting his desk in his apartment. R3's Service Plan dated August 27, 2021, and signed by R3 on September 27, 2021, indicated R3 received assistance with housekeeping, checking pendant, dressing, meals, laundry, temperature assessment, oxygen saturation assessment, toileting, escort services, and medication administration. R3 was hospitalized from October 1, 2021, through October 5, 2021. R3's hospital discharge orders included, but were not limited to, Amiodarone (treats serious irregular heartbeat), Eliquis (blood thinner), and Metoprolol (treats high blood pressure). R3's October 2021 medication administration record (MAR) included the current medications as listed above. R3's MAR lacked the medication Amiodarone on October 9, 2021; therefore, R3 did not receive the medication as ordered. On October 12, 2021, at 11:07 a.m., RN-A stated when R3 returned from the hospital on October 5, 2021, the new order for Amiodarone was transcribed, but the Amiodarone was omitted	01760		

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01760	Continued From page 67 from the MAR for October 9, 2021; therefore, R3 did not receive the medication that day. The licensee's undated policy, Implementation of Medication Orders, indicated medications must be administered as prescribed by a nurse qualified to "implement" the order. In addition, the RN will monitor whether prescriptions and orders have been implemented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 68 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 observation, interview, and record	01790		

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review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. The licensee failed to ensure one of one ULP (ULP-A) was trained and demonstrated competency to the RN to prepare and give medications for residents having unplanned time away.

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 October 11, 2021, at approximately 11:40 a.m., the corporate director of nurses (CDON)-E and registered nurse (RN)-A confirmed the licensee provided medication management services to the majority of residents at the facility.

On October 13, 2021, at approximately 11:09 a.m., RN-A stated there was no written procedures for ULPs providing medications for residents having unplanned time away when she was not available. RN-A confirmed ULP-A would prepare and send medications for residents for unplanned times away.

When interviewed on October 13, 2021, at approximately 2:20 p.m., ULP-A stated she had

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01790	Continued From page 70 worked at the facility for almost two years and was trained by the previous ULP lead care manager (who was not a licensed nurse) to prepare and give medications for residents having unplanned time away. ULP-A stated she would pack the residents' medications in envelopes and complete a form that the resident was given if she knew ahead of time that the resident was going to be out of the facility. If she was unavailable to do this, she had trained the other ULP staff how to do this. On October 13, 2021, at approximately 2:40 p.m., RN-A stated she had not trained ULP-A or any other ULP to prepare and give medications for residents having unplanned time away from the facility because ULP-A was trained by the previous lead care manager, and ULP-A had trained the other ULP staff. RN-A indicated she was unaware of the requirement for development of a written procedure for the ULP providing medications for residents having time away from the facility and that ULP staff needed to be trained and demonstrate competency to the RN. The licensee's policy, Medications When a Resident Is Away from the Community, undated, indicated, if the resident and/or the responsible person notified the RN prior to a planned absence from the building, the RN or the pharmacist would set up the medications for the resident. In addition, the policy indicated, for unplanned absences the RN may delegate this task to unlicensed staff if the RN trained and competency tested the unlicensed staff on procedures to follow when giving medications to residents who will be away from home when medications are scheduled, and the RN would train staff to complete the Checklist for Medications Sent.	01790		

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01790	Continued From page 71 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information and to date time sensitive medications with a date when opened for two of two residents (R2 and R5) with records reviewed with insulin. 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: During the entrance conference on October 11, 2021, at approximately 11:40 a.m., registered	01890		

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nurse (RN)-A stated the licensee provided medication management services to the licensee's residents.

On October 11, 2021, at approximately 12:45 p.m., a review of the licensee's two medication carts was completed. The following was observed and confirmed with RN-A:

R3's Novolog FlexPen insulin was placed in the top drawer in a plastic box with the R3's room number on the box. The insulin lacked a prescription label with the required content. The pen had a small sticker on it, which noted the pen had been opened on September 4, 2021, and would expire on February 2023. R3 had a Lantus SoloStar insulin pen without a pharmacy label. The pen had a small sticker on it, which noted it had been opened September 19, 2021, and lacked a date it would expire.

R5's Novolog FlexPen was placed in the top drawer in a plastic box with R5's room number on the box. The insulin pen lacked a prescription label with the required content. The pen had a small sticker on it, which noted the pen had been opened on October 8, 2021, but lacked a date when the pen would expire.

At this time, RN-A stated the resident's insulin came in a box and the box contained the pharmacy label, but the pharmacy did not provide labels for each individual pen. RN-A stated the date the Novolog FlexPen would expire on February 2023 was not correct.

On October 12, 2021, at approximately 11:00 a.m., unlicensed personnel (ULP)-A was observed administering insulin to R5 in his room. After administration, ULP-A confirmed the date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30489	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POTTER RIDGE	1971 NEAL STREET RED WING, MN 55066

(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
01890	Continued From page 73 the insulin would expire was not noted on the pen, and stated it would be good for "about 30 days" after it was opened. ULP-A stated she was not aware of a list provided to indicate how long medications would be good after opened. The manufacturer's instructions for Novolog dated June 2021 directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Lantus dated 2020 directed to discard the pen 28 days after opening, even if it had insulin in it. The licensee's Central Storage of Mediations policy, undated, lacked information on prescription labels or dating time sensitive medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or 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	01910		

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01910	Continued From page 74 and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication, to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R4) with 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: R4's record lacked documentation of medication disposition upon R4's discharge from the facility. R4 was discharged on October 8, 2021, after receiving services for diagnoses including, but not limited to, congestive heart failure, memory loss, and chronic kidney disease.	01910		

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01910	Continued From page 75 R4's service plan dated August 1, 2021, indicated R4 received services, which included medication administration, meals, laundry, and housekeeping. R4's discharge summary, dated October 8, 2021, indicated R4's medications included, but were not limited to, an iron supplement, diuretic, blood thinner, and antihypertensive. R4's discharge summary did not include the disposition of the medications. R4's record lacked evidence of documentation of R4's disposition of medications to include: name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On October 12, 2021, at approximately 4:02 p.m., registered nurse (RN)-A stated she remembered completing a disposition of R4's medications and realized it was sent with R4 upon discharge, but a copy had not been kept for R4's record. The licensee's Disposition of Medications policy, undated, indicated the residents' current medications would be given to the resident or the resident's responsible person when the resident was discharged, and the staff would document to whom the medications were given, the time, date, and name of each medication on the Medication Disposition/Disposal Form. The policy also indicated a copy of the destruction record form must be kept on file at the building for two years. No further information was provided.	01910		

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01910	Continued From page 76 TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced	01940		

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01940	Continued From page 77 by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on October 11, 2021, at approximately 11:40 a.m., registered nurse (RN)-A stated the licensee provided treatment management services to residents, including, but not limited to, blood glucose checks and oxygen assistance. R2's record lacked a treatment management plan to include the following required content: - a statement of the type of service that would be provided - documentation of specific resident instructions relating to the treatments or therapy administration - identification of treatment or therapy tasks that would be delegated to unlicensed personnel - procedures for notifying a registered nurse when a problem arose with treatments or therapy services - any resident-specific requirements relating to documentation of treatment and therapy received,	01940		

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01940	Continued From page 78 verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R2's Service Plan dated June 14, 2021, indicated R2 received services including, but not limited to, glucometer checks and medication administration. On October 12, 2021, at approximately 11:15 a.m., unlicensed personnel (ULP)-A was observed performing a blood glucose check on R2 in his apartment. R2's prescriber orders dated June 14, 2021, instructed staff to check blood sugars three times per day. R2's Service Recap Overall for October 2021 listed record glucose three times daily with staff initials to indicate the service was completed. On October 13, 2021, at approximately 10:15 a.m., registered nurse (RN)-A verified a treatment management plan with the required content had not been developed for R2. The licensee's Content of the Resident Record policy, undated, indicated the resident record would contain an individualized treatment and/or therapy plan, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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02240	Continued From page 79	02240		
02240 SS=A	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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02240	Continued From page 80	02240		

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 acknowledgement of receipt of the current home care bill of rights was obtained 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

On August 1, 2021, the new Assisted Living Bill of Rights went into effect in the State of Minnesota.

R3 lived in the facility prior to August 1, 2021, and continued to live and receive services in the facility as of October 11, 2021.

On October 11, 2021, R3's record did not contain written acknowledgement of receipt of the current Assisted Living Bill of Rights.

On October 12, 2021, at approximately 8:09 a.m., R3 was sitting at his desk in his apartment. When

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02240	Continued From page 81 asked if he had received the updated Assisted Living Bill of Rights, R3 stated, "No, what's that?" The licensee's undated policy, Resident Rights, indicated, before receiving services, residents have the right to be informed by the facility of the rights granted under this section and the recourse residents have if violated. The policy lacked direction to ensure written acknowledgement of receipt of the current home care bill of rights was obtained. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
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, interview, and record review, 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 any visitors of the licensee.	03090		

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03090	Continued From page 82 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: On October 11, 2021, at approximately 11:00 a.m., upon entering the facility, an observation outside and inside the front entrance revealed no posting for electronic monitoring devices as required. On October 11, 2021, at approximately 12:10 p.m., during the facility tour with corporate director of nursing (CDON)-E, the above required information was not observed to be posted throughout the facility. At this time, CDON-E confirmed the required information was not posted, and stated there currently were no cameras in use. The licensee's Electronic Monitoring policy, undated, noted the licensee would post a sign at the entrance accessible to visitors that stated "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Food, Pools, Lodging
18 Woodlake Dr. SE
Rochester
507-206-2700

Type: Full
Date: *10/11/21*
Time: 14:02:55
Report: 8074211132

Food and Beverage Establishment Inspection Report

Location:
Potter Ridge
1971 Neal Street
Red Wing, MN55066
Goodhue County, 25

Establishment Info:
ID #: 0038867
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513881546
ID #:

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

The following orders were issued during this inspection.

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.

upright cooler holding food 45-47 df. turn unit down and if it does not lower to below 41df place food in worktop cooler and repair.
Comply By: 10/13/21

3-500A Microbial Control: cooling
3-501.15A ***** Priority 2 *****
MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.

Ribs cooling in deep, covered, plastic container 121 df, chicken and sauce cooling in deep, covered containers. Corrected on site by venting and using ice bath.
Comply By: 10/11/21

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.

water filter last dated 2018
Comply By: 10/20/21

4-400 Equipment Location and Installation

4-402.11A

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

Caulk of spray sink needs is black and needs to be replaced.
Comply By: 10/21/21

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: sanitizer bucket
Violation Issued: No

Chlorine: = 50ppm at Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Work Top Cooler
Temperature: 36 Degrees Fahrenheit - Location: salad
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 45 Degrees Fahrenheit - Location: potatoes
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 47 Degrees Fahrenheit - Location: carrot
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 48 Degrees Fahrenheit - Location: chicken
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 82 Degrees Fahrenheit - Location: chicken sauce (cooling 1 hour)
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 121 Degrees Fahrenheit - Location: ribs (cooling 1 hour)
Violation Issued: No

Type: Full
Date: *10/11/21*
Time: 14:02:55
Report: 8074211132
Potter Ridge

Food and Beverage Establishment Inspection Report

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

For any plan review questions contact HRD engineering services.

All fact sheets can be found here:

https://www.health.state.mn.us/communities/environment/food/fs.html

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 8074211132 of 10/11/21.

Certified Food Protection Manager: Amalia Christenson

Certification Number: FM107618 Expires: 08/16/24

Signed: _____
Establishment Representative

Signed: _____
Inspector #8074

651-201-4500
health.foodlodging@state.mn.us

Report #: 8074211132

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, Lodging
18 Woodlake Dr. SE
Rochester

No. of RF/PHI Categories Out	1	**Date**	10/11/21
No. of Repeat RF/PHI Categories Out	0	**Time In**	14:02:55
Legal Authority MN Rules Chapter 4626		**Time Out**	

Potter Ridge	**Address** 1971 Neal Street	**City/State** Red Wing, MN	**Zip Code** 55066	**Telephone** 6513881546
License/Permit # 0038867	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

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		
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	X	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		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		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 10/13/21

Inspector (Signature)