Electronically Delivered

April 15, 2025

Licensee
Kingsway Retirement Living
815 West Main Street
Belle Plaine, MN 56011

RE: Project Number(s) SL30661016

Dear Licensee:

On March 18, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the December 12, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Electronically Delivered

January 24, 2025

Licensee
Kingsway Retirement Living
815 West Main Street
Belle Plaine, MN 56011

RE: Project Number(s) SL30661016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 12, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH 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.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be 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.

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

St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at

the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30661016 On December 9, 2024, through December 12, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 72 residents; 44 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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 evaluators ' 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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. 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 10, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of four unlicensed personnel (ULP-G, ULP-H) complied with accepted health care, medical, and nursing standards for infection control with proper hand hygiene. 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:	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
0 510	Continued From page 4 On December 10, 2024, at 12:46 p.m., the surveyor continuously observed ULP-G serving food and beverages to the residents in the dining room. ULP-G did not use hand sanitizer or wash hands. ULP-G went to the office, set up R8's medications for administration. ULP-G brought the medications to R8 at the kitchen table, filled a glass of water in the kitchen, and gave R8 the medications and the water. ULP-G returned to the office and did not use hand sanitizer or wash their hands. ULP-G set up R9's medications for administration. ULP-G went to the kitchen and filled a glass with water and administered the medications to R9. ULP-G returned to the office and stated he had completed the medication pass. ULP-G did not use hand sanitizer or wash his hands. On December 11, 2024, at 7:54 a.m., the surveyor continuously observed ULP-H set up oral medications for administrations for R11, ULP-H went to R11's room and administered the medications. ULP-H did not use hand sanitizer or wash hands. ULP-H went to R3's room, put a transfer belt on R3, and assisted R3 to ambulate with a walker to the dining room and transfer to a dining room chair. ULP-H went to the kitchen area and poured a cup of coffee, put on gloves, prepared a breakfast tray and delivered it to R3. ULP-H then removed gloves and returned to the office. ULP-H did not use hand sanitizer or wash hands. ULP-H set up medications for R7, went to R7's room, administered the medications and returned to the office. ULP-H did not use hand sanitizer or wash her hands. On December 12, 2024, at 11:32 a.m., clinical nurse supervisor (CNS)-B stated staff should use hand sanitizer or wash hands between	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
0 510	Continued From page 5 medication passes and between contact with residents. The licensee's 8.09 Hand washing policy dated June 8, 2024, indicated hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contaminations. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
0 630	Continued From page 6 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: R2 On December 10, 2024, at 7:13 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R2. R2 was sitting in a wheelchair with their left hand and arm in a cast to just above the elbow. When the surveyor asked R2 what happened to their arm, R2 stated "I don't remember". R2 was admitted on January 28, 2023, with diagnoses including anxiety, atrial fibrillation, history of stroke, and cognitive impairment. R2 resided in the secured dementia care unit within the facility. R2's Service Plan signed September 11, 2024, indicated R2 received services including bathing, ambulation, compression stockings, behavior management, transferring, toileting, and medication management. R2's IAPP dated November 19, 2024, indicated R2 was at risk for abuse and interventions to prevent abuse; however, R2's IAPP did not indicate if R2 was at risk of abusing others as required. R3 On December 10, 2024, at 8:22 a.m., the	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
0 630	Continued From page 7 surveyor observed ULP-D bring R3 his insulin and step by step cued R3 on self administration of insulin. R3 stated he was unable to see the numbers to dial the correct dose of insulin. ULP-D informed him when to stop dialing the pen for the correct dose. R3 was admitted on February 19, 2024, with diagnoses including debility (weakness), diabetes, kidney disease, chronic obstructive pulmonary disease, congestive heart failure, and anxiety. R3's Service Plan signed December 4, 2024, indicated R3 received services including bathing, escorts to meals, exercise, and medication administration. R3's IAPP dated December 5, 2024, indicated R3 was at risk for abuse and interventions to prevent abuse; however, R3's IAPP did not indicate if R3 was at risk of abusing others as required. R4 On December 10, 2024, at 9:01 a.m., the surveyor observed ULP-F apply compression stockings on R4. R4 was admitted on August 6, 2024, with diagnoses including dementia and high blood pressure. R4 resided in the secured dementia care unit within the facility. R4's service plan signed August 5, 2024, indicated R4 received services including bathing, dressing, grooming, compression stockings, and medication administration. R4's IAPP dated November 18, 2024, indicated	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
0 630	Continued From page 8 R4 was at risk for abuse and interventions to prevent abuse; however, R4's IAPP did not indicate if R4 was at risk of abusing others as required. On December 12, 2024, at 12:15 p.m., clinical nurse supervisor (CNS)-B stated she was unaware the IAPPs did not include the residents risk for abusing others. At 1:28 p.m., CNS-B further stated that sometimes things can change with a resident or with a disease process the resident can change, so the nurse completing the assessments did not feel comfortable saying the residents were at risk to abuse others. The licensee's 6.05 Individual Abuse Prevention Plan policy dated September 13, 2023, indicated all residents would have an individual abuse prevention plan. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
0 660	Continued From page 9 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 a facility TB risk assessment completed annually. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
0 660	Continued From page 10 MDH was completed December 9, 2024 (after the survey began), and identified the facility was at a low TB risk. On December 9, 2024, at 3:44. p.m., clinical nurse supervisor (CNS)-B stated the last time the TB facility risk assessment had been completed was in 2022; therefore, she had completed the assessment after it was requested by the surveyor. 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 a facility TB risk assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 11 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide carbon monoxide detectors in resident rooms. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on December 10, 2024, from 8:58 a.m. through 10:53 a.m., with executive director (ED)-A and director of maintenance (DM)-C, the surveyor observed that carbon monoxide detection was not provided in resident rooms, which contained natural gas furnaces. Dwelling units and sleeping units that contain a fuel burning appliance shall be equipped with carbon monoxide detection within ten feet of bedrooms.	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 12 ED-A and DM-C stated that there were carbon monoxide detectors in the boiler room and other common areas that contained a fireplace or other fuel burning appliance. The surveyor explained that since each resident room contained a fuel burning appliance, each resident room would need to be equipped with carbon monoxide detection within the resident room. ED-A and DM-C verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for for all three residents (R2, R3, R4) residing in the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
0 970	Continued From page 13 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: R2's Senior Living Contract signed was signed by R2 on January 17, 2023. R3's Senior Living Contract signed was signed by R3's responsible party on February 16, 2024. R4's Senior Living Contract signed was signed by R4 on August 5, 2024. R2, R3, and R4's Senior Living Contract contained the following statements: "INDEMNIFICATION Resident will indemnify and hold harmless Provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or any other part of Provider's property, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents." "LIABILITY Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment Unit or on Provider's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. Provider is also not liable for any injury, death or damage occurring as the result of	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
0 970	Continued From page 14 Resident's receipt of health-related, supportive or other services from third party providers. Provider may be liable to Resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on Provider's premises." On December 9, 2024, at 3:33 p.m., executive director (ED)-A stated she was unaware the contract waived the licensee's liability and all contracts were the same. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
01060	Continued From page 15 Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content, to the resident, legal representative, and designated representative, for an emergency relocation for two of two residents (R1, R3). In addition, the licensee failed to notify the Office of Ombudsman for Long-Term Care of the relocation that lasted longer than four days as required. This practice resulted in a level two violation (a	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
01060	Continued From page 16 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: R1 R1's Discharge Care Plan dated July 16, 2024, indicated R1 was hospitalized on June 1, 2024, and then transferred to a transitional care unit. R1 was discharged from the facility on July 16, 2024. R1's record lacked evidence the resident and/or the resident's representative had been provided, as soon as practicable, a written notice that contained, at a minimum: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54 and the contact information for the agency to which the resident may submit an appeal. R1's record also failed to indicate the Office of Ombudsman for Long-Term Care had been	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
01060	Continued From page 17 notified of the relocation when R1 had not returned to the facility within four days. R3 R3's Resident Notes indicated the following: - On November 11, 2024, at 5:31 p.m., R3 was not feeling well and was "shaky" and pale. Vital signs indicated a pulse of 105 (normal pulse 60-100), oxygen saturation level of 83% on room air (normal is 95-100%), Temp [temperature] of 98.0, and respirations of 22. R3's family member call and R3 was sent to the hospital by ambulance. - On November 12, 2024, at 8:15 a.m., R3's family member notified the facility he was hospitalized with pneumonia. - On December 21, 2024, R3 returned from the hospital. R3's record lacked evidence the resident and/or the resident's representative had been provided, as soon as practicable, a written notice that contained, at a minimum: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54 and the contact information for the agency to which the resident may submit an appeal.	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
01060	Continued From page 18 R3's record also failed to indicate the Office of Ombudsman for Long-Term Care had been notified of the relocation when R3 had not returned to the facility within four days. On December 9, 2024, at 2:35 p.m., clinical nurse supervisor (CNS)-B stated the facility had not been completing an emergency transfer form or notifying the ombudsman of emergency transfers, and she was unaware of the statute. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=I	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
01620	Continued From page 19 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 complete change in condition assessment after falls for one of one resident (R2), resulting in actual harm when R2 incurred a significant injury. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 10, 2024, at 7:13 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R2. R2 was sitting in a wheelchair with their left hand and arm were in a cast to just above the elbow. When the surveyor asked R2 what happened to their arm, R2 stated "I don't remember". R2 was admitted on January 28, 2023, with diagnoses including anxiety, atrial fibrillation, history of stroke, and cognitive impairment. R2 resided in the secured dementia care unit within the facility. R2's Service Plan signed September 11, 2024,	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
01620	Continued From page 20 indicated R2 received services including bathing, ambulation, compression stockings, behavior management, transferring, toileting, and medication management. R2's Incident Report dated October 2, 2024, indicated at 6:45 a.m. ULP-E found R2 on the floor in their bedroom. ULP-E documented the fall was unwitnessed. R2 was walking with their walker without staff assistance in their room. R2 was found by ULP-E on the floor near the doorway of their room with their walker in front of them. R2 told ULP-E they were "trying to get out of this door". ULP-E notified the licensed practical nurse (LPN-I) of the fall. LPN-I documented the following: - the medical provider and family had been notified - additional insights into fall- it appeared R2 was trying to get out of their room into the hallway - immediate actions taken - R2's blood pressure and respirations were elevated and would be rechecked - actions taken to prevent future falls - R2 was spontaneous at times and had a bed alarm but not a chair alarm - explanation of fall including any pertinent information about what was done at the time of the by facility staff - "Just wanting to come out of her room? Observed scooting herself on her bottom coming out of her room." R2's Progress Notes dated October 2, 2024, at 4:01 p.m., indicated a post fall note of vital signs were rechecked and were within normal limits. No further information. R2 was up per her norm and cheerful. R2's record lacked evidence a significant change assessment, post fall assessment, or root cause	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
01620	Continued From page 21 analysis of the fall with appropriate interventions to prevent further falls had been completed by a registered nurse (RN). R2's Incident Report November 5, 2024, indicated at 3:00 a.m. R2's bed alarm was sounding and R2 had an unwitnessed fall. ULP-J documented R2 was trying to sit in their chair, slipped off and was found laying on floor on left shoulder. R2 was assisted by staff to transfer to their wheelchair. No injuries were noted at the time of the fall. R2 complained of left shoulder pain but no injury was noted to that area. LPN-I was notified of the fall. LPN-I documented the following: - medical provider had been notified - family member had been notified at 8:00 a.m. of the fall and was coming to the facility - did the fall result in a serious injury - yes "staff had reported some left shoulder discomfort this am - after an hour noted swelling/bruising to the left wrist/forearm - elevated ice pack applied". - actions taken to prevent future falls - "Frequent checks during the night?" - Review of the fall including a root cause analysis - "Resident does have a bed alarm, which does alarm staff - did not get there in time?" - additional comments - "Resident was taken to [hospital] ER by son for an evaluation, etc". No further information was provided. R2's Progress Notes included the following on November 5, 2024: - at 12:22 p.m. by RN-K documented she was notified of R2's fall at 8:00 a.m. R2 was sitting at the dining room table with her left wrist elevated on a pillow. Left wrist was noted to be swollen with bruising on the inside of the wrist. R2 complained of pain with any movement. RN-K notified R2's family member. R2's arm was	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
01620	Continued From page 22 secured with a sling and R2 was transported to the emergency room with her family member at 10:00 a.m. - at 4:18 p.m. RN-K documented the emergency room called at 3:35 p.m. and reported R2 had a closed fracture of the left distal radius and ulna. The fractures were reduced in the emergency room and a cast was applied. R2 returned to the facility at 3:35 p.m. with her family member. R2 had no complaints of pain. R2 had a cast on her left arm. Staff were to attempt to keep R2 non-weight bearing on the left arm and keep the arm in a sling at all times as R2 allows/tolerates. R2's record lacked evidence a significant change assessment, post fall assessment, or root cause analysis of the fall with appropriate interventions to prevent further falls had been completed by a RN. On December 12, 2024, at 9:02 a.m., RN-K stated there was no further documentation, root cause analysis or assessments of R2 or of her falls, and no additional interventions were put into place after either fall. The information in the incident report and in the progress notes was the only information regarding the falls. The LPN followed up on those falls because she was the one on call, there is no further follow up completed by an RN. No change in condition was noted so no change in condition assessment was completed. The injury was noted and that was assessed, but no further assessment was completed. On December 12. 2024, at 12:21 p.m., clinical nurse supervisor (CNS)-B stated her expectation is a root cause analysis would have been completed with any fall, and interventions would have been put into place. It had been the facility's	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
01620	Continued From page 23 practice that an LPN on call was able to follow up on a fall without requiring a RN to further assess. The licensees 6.01 Assessments, Reviews & Monitoring policy dated September 13, 2023, indicated reassessment must be completed as needed with changes in condition and changes in needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01620		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were labeled with the date open and failed to ensure medications were maintained bearing the original prescription label for one resident (R3) in one of four medication carts (second floor medication cart). 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	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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 24 residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 10, 2024, at 8:22 a.m., the surveyor reviewed the second floor medication cart with unlicensed personnel (ULP)-D and identified the following medications for R2: - atropine eye drops with a pharmacy label that contained the resident's name and the name of the medication; however, the label lacked the prescription number and the directions for use; - Timolol eye drops with a pharmacy label that contained the resident's name and the name of the medication; however, the label lacked the prescription number and the directions for use; - Humalog Mix 75/25 KwikPen which did not have an open date marked on the pen; and - Ozempic pen which did not have an open date marked on the pen. On December 10, 2024, at 10:50 a.m., the surveyor observed the medication cart as noted above with clinical nurse supervisor (CNS)-B. CNS-B stated all medications should have a full pharmacy label, and time sensitive medications should be dated when opened. Humalog Mix 75/25 KwikPen, undated, prescribing information identified "The HUMALOG Mix 75/25 Pen you are using should be thrown away after 10 days, even if it still has insulin left in it." Ozempic prescribing information dated December 2017, identified "Store your pen in use for 56 days below 86ºF (degrees Fahrenheit)".	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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 25 The licensee's 7.11 Medication Storage policy dated September 13, 2023, indicated all medications would be stored consistent with manufacturer's recommendations. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 26 possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure it developed an individual treatment management plan for one of three residents (R2) who received treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 10, 2024, at 9:33 a.m., the surveyor observed unlicensed personnel (ULP)-E complete a dressing change to R2's cheek wound. ULP-E removed the dressing, cleaned the wound with wound spray and a gauze pad. ULP-E then applied Bacitracin to the wound and placed a clean dressing. R2's Service Plan signed September 11, 2024, indicated R2 received services including bathing, ambulation, compression stockings, behavior management, transferring, toileting, and medication management. R2's Service Plan did not include wound care. R2's comprehensive assessment dated	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 27 November 19, 2024, indicated R2 did not have any wounds. R2's physician orders dated November 4, 2024, indicated staff were to keep wound to right cheek covered and surgery would be scheduled with dermatology. R2's physician orders dated December 2, 2024, indicated staff were to put Bacitracin ointment on wound during dressing changes. On December 12, 2024, at 2:26 p.m., clinical nurse supervisor (CNS)-B stated wound care should have been included in R2's service plan and when the wound care was initiated, a new service plan should have been printed and signed. The licensee's 7.05 Treatment & Therapy Management Plan policy dated September 13, 2023, indicated the facility would include in the service plan a written statement of the therapy or treatment services that will be provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
02110	Continued From page 28 based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required for assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in for three of three residents (R2, R3, R4).	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
02110	Continued From page 29 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living with dementia care license effective August 1, 2024. R2, R3, and R4's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including non-pharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
02110	Continued From page 30 systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On December 12, 2024, at 3:45 p.m., executive director (ED)-A stated the facility provided the residents with the dementia training information and she thought that was the requirement. ED-A further stated the facility had the required policies, but was unaware they had to be provided to the residents and their legal and their designated representatives at the time of move in. The licensee's 3.00 Assisted Living with Dementia Care Additional Required policies dated October 21, 2021, indicated because [licensee's name] had an Assisted Living with Dementia Care license, in addition to the policies and procedures required for the facility written policies and procedures must include additional dementia related policies. In addition, these policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. The policies can be provided in electronic format if desired. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including:	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
02140	Continued From page 31 (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person to oversee staff training in the care of individuals with dementia completed the required skills competency or knowledge test required by the commissioner. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee was licensed as an assisted living facility with dementia care (ALFDC). On December 9, 2024, at 11:00 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated she was responsible to provide direct resident cares and supervision of unlicensed staff. CNS-B stated the licensee used Relias (training software) to complete the required dementia training and she completed the	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
02140	Continued From page 32 same training as the rest of the licensee's staff. CNS-B's Relias training transcript identified training as completed on June 29, 2023 in Alzheimer disease and related disorder with topics including activities, ADL (activities of daily living) care, approaches to treatment, behaviors, communication needs, ethical and family issues, the disease process, and the environment. On April 9, 2024, she had completed the topics of approaches to treatment and behaviors. On October 4, 2024, she had completed the topic of communication needs. On December 9, 2024, she had completed the topic of Ethical and family issues. Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions Dementia care training programs required to ensure compliance with statute 144G.83 are listed and Relias was not included in the list. On December 12, 2024, at 8:30 a.m., executive director (ED)-A stated she was unaware the Relias training did not meet the requirement according to the approved list provided by the commissioner. ED-A further stated the supervising staff had not completed training and skills competency testing with any of the provider's approved by the commissioner. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
02320	Continued From page 33 (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow delegated procedures for the licensee's one resident (R3) receiving medication reminders for insulin administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 10, 2024, at 8:22 a.m., unlicensed personnel (ULP)-D removed R3's Humalog 75/25 KwikPen insulin from the medication cart and checked to the the medication reminder task and went to R3's room with the insulin pen, an alcohol prep pad, an insulin needle, and a sharps container. ULP-D stated since R3 had been in the hospital, the staff had been verbally cuing him through the process. ULP-D removed the cover to the needle and instructed R3 to open the insulin and put the needle on. ULP-D handed R3 an alcohol prep pad and instructed R3 to clean	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
02320	Continued From page 34 his belly, which R3 completed. ULP-D directed R3 to turn the dial on the insulin 36 units. R3 stated he could not see it. ULP-D stated "you have to twist this, start turning it." R3 stated he couldn't see it. ULP-D told R3 to start turning and she would tell him when to stop. R3 stopped a couple of times and ULP-D told R3 to keep going. When the insulin pen was at 36 units, she told R3 to stop. ULP-D then directed R3 to push the insulin pen against his abdomen where he had cleaned and pushed the button. R3 injected the insulin and immediately removed the needle. ULP-D asked R3 to remove the needle and had him place it into the sharps container, and he covered the insulin. The following steps were not completed or were completed improperly (according to manufacturer directions) during the process: - the port was not cleaned on the insulin pen with an alcohol prep pad prior to attaching the needle; - the insulin was not mixed by rolling and inverting the insulin pen; - the insulin pen was not primed with 2 units prior to injection; and - the dose knob was not held in and count to five completed before removing needle after injecting the insulin. ULP-D stated she could not remember who had trained her for insulin administration, but they were just giving R3 reminders and he was self-administering. R3's medication reminder task dated February 19, 2024, indicated the following: - Staff were to remind resident to take the medication as prescribed- bring insulin pen, alcohol wipes, unopened needle (to attach to insulin pen), and small red sharps container to resident room to self-administer insulin. - Resident to mix insulin in the pen, attach needle	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
02320	Continued From page 35 to insulin pen, dial dose (36 units before breakfast and 8 units before supper), cleanse area on skin to administer insulin with alcohol wipe, and administer the insulin himself. Then resident is to remove the needle from the insulin and put it in the sharps container. Bring sharps container back to the medication cart. The insulin pen can be stored in the medication cart. Refills are stored in the refrigerator. Speak with the nurse if you have any questions or concerns. R3's Service Plan signed December 4, 2024, indicated R3's services included medication administration, blood glucose monitoring, and medication reminders. R3's Progress Notes indicated R3 was hospitalized from November 11, 2024, through November 21, 2024 for pneumonia. R3's comprehensive assessments dated November 11, 2024, and December 5, 2024, indicate R3 receives full medication management and administration except for insulin and Ozempic injections; resident self-administers with reminders. No further self-administration assessment information for the injections indicated on the comprehensive assessments. On December 10, 2024, at 10:21 a.m., clinical nurse supervisor (CNS)-B stated R3 was supposed to be self-administering the insulin. Staff were only supposed to be bringing him the insulin and supplies and giving him a reminder to self-administer. If R3 was having any problems with self-administration, staff should have notified the nurse. ULP-D should not be directing R3 or assisting him with the administration in any way, but instead should have called the nurse. At 1:42 p.m., CNS-B further stated the staff were not	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
02320	Continued From page 36 trained for insulin administration and that was not a service provided. The residents need to be able to self-administer or self-administer with med reminders. The licensee's Medication and Treatment Reminders Competency dated October 22, 2021, indicated staff were to be able to: - identify where to find the correct time for the medication or treatment reminder; - identify the location of the medication or treatment; - identify the person to notify if a medication needs to be refilled; and - identify the person to notify if client is not taking the medication as prescribed, or refusing medications or treatments. Humalog Mix 75/25 KwikPen undated prescribing information identified: 1. Pull of the pen cap and wipe the rubber seal with alcohol swab 2. Gently roll the pen ten times, invert the pen ten times. The insulin should look cloudy after mixing. 3. Pull off the paper from the outer needle shield 4. Push the capped needle straight onto the pen and turn the needle forward until it is tight 5. Pull off the outer needle shield and the inner needle shield. 6. Turn the dose knob to select 2 units. 7. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. 8. Hold your pen with the needle pointing up. Push the dose knob until it stops and a "0" is seen in the dose window. Hold the dose knob in and count to 5 slowly. - a stream of insulin should be seen from the needle, if not repeat steps 6-8 9. Turn the dose knob to select the number of	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30661	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSWAY RETIREMENT LIVING	815 WEST MAIN STREET BELLE PLAINE, MN 56011

(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
02320	Continued From page 37 units you need to inject. The dose indicator should line up with your dose. 10. select your injection site and clean it with an alcohol swab. 11. insert the needle into your skin. 12. Push your thumb on the dose knob and push the dose knob until it stops. Hold the dose knob in until it stops and slowly count to 5. 13. pull the needle out of your skin. You should see "0" in the dose window. 14. Carefully replace the outer needle shield 15. unscrew the capped needle and throw it away. 16. replace the pen cap. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *12/10/24*
Time: 10:00:00
Report: 1047241345

Food and Beverage Establishment Inspection Report

Location:

Kingsway Retirement Living
815 West Main Street
Belle Plaine, MN56011
Scott County, 70

Establishment Info:

ID #: 0037818
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528735900
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

NO EMPLOYEE ILLNESS LOG AVAILABLE AT TIME OF INSPECTION. EXAMPLE LOG SENT WITH REPORT.

Comply By: 12/10/24

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO METHOD IN PLACE TO MEASURE UTENSIL SURFACE TEMPERATURE IN DISHWASHER. DISCUSSED OPTIONS OF GETTING A THERMOMETER, THERMAL STRIPS, OR ALTERNATE METHOD.

Comply By: 12/10/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: 3 comp sink
Violation Issued: No

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

Hot Water: = at 168 Degrees Fahrenheit
Location: Dishmachine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 177 Degrees Fahrenheit - Location: Steam table- soup
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Prep cooler- ham
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Fridge 1- cheese
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Fridge 2- salad
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Walk in #1- raost beef
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Walk in #2- lettuce
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Memory care- yogurt
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Floor 2- yogurt
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Floor 3- milk
Violation Issued: No

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

Inspection conducted with K. Waller & reviewed with MDH Nurse Evaluator S. Haag.

The establishment has a commercial kitchen where all the food for the facility is prepared. All the sanitizing of utensils occurs in this main kitchen. The facility also has three satellite kitchens- one for the memory care unit, one on floor 2, and one on floor 3.

The satellite kitchens have wood cabinets, laminate floor, painted walls, solid counter top, and a painted ceiling. They also have two basins sinks, one basin of which can be used for handwashing.

Type: Full
Date: *12/10/24*
Time: 10:00:00
Report: 1047241345
Kingsway Retirement Living

Food and Beverage Establishment Inspection Report

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures,cleaning, serving highly susceptible populations, and food handling procedures

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 1047241345 of 12/10/24.

Certified Food Protection Manager Kathi J. Waller

Certification Number: FM95441 Expires: 09/06/27

Inspection report reviewed with person in charge and emailed.

Signed:_____
Kathi Waller

Signed:_____
Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us